University of Alberta

Adolescent Females' Sexual Behaviour: An Exploration of Protective Factors and Counselling Strategies

by

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A thesis submitted by the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of
MASTER OF EDUCATION

In

Counselling Psychology

Department of EDUCATIONAL PSYCHOLOGY

Edmonton, Alberta

Spring 2005

0-494-08011-6

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Abstract

Aspects of school and family were studied to determine whether they promote sexually healthy behaviours in adolescent females. The author examined which school-related factors best predict contraceptive use at first intercourse for adolescent females, and whether or not parent-adolescent communication is related to females' sexual debut (age and contraceptive use at first intercourse). A general counselling approach to empower young females to act in healthy ways is presented.

Data from 123 sexually active females from rural Alberta, who completed a questionnaire, was examined. Out of five school-related factors (GPA, educational aspirations, attachment to school, weekly studying, and weekly homework time), *weekly studying time* was found to significantly predict contraceptive use at first intercourse. Also, females reporting no communication with their parents regarding sex, engaged in sex at significantly earlier ages than females reporting communication.

A general counselling approach following a strengths-based philosophy is suggested to extend "resiliency building" and to promote healthy behaviours at the individual level.

Acknowledgements

I would like to thank Dr. Gretchen Hess for understanding the meaning of being a true teacher, for helping me grow wings by having faith in my abilities and for giving me the space to find them myself. Thanks to my family for believing in me and for all of their supportive words of encouragement. Thanks to Jen, Katherine, Lynne, Regina and Tula, for your support throughout my many transformations these past three years. I would also like to thank my friends for listening and reassuring me. Finally, to my husband and son, Jay and Jack, you guys have supported me to no end. Thank you for your patience and your confidence in me, without it I would still be writing or may have never embarked on this educational and spiritual journey.

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Chapter 1 - Introduction

Statement of the Problem

Sexual risk-taking behaviours in adolescence, such as engaging in sex at an early age and inconsistent contraceptive use, can lead to unwanted pregnancies and sexually transmitted infections (STI's). For sexually active teens, age at first intercourse has declined and less than half of females report using condoms consistently when compared to males (O'Donnell, O'Donnell, & Stueve, 2001). In addition to physical consequences of sexually risky behaviour, emotional costs can arise, especially for female teens. Many adolescent females report that they feel they were "too young" when reflecting back upon their age at first intercourse and more females than males report negative feelings regarding their first sexual experience (Cotton, Mills, Succop, Biro, & Rosenthal, 2004; Hess, Chan, & Denkhaus, 2002). Many teen girls are impacted by cultural messages around sexuality and femininity, and these standards can impact the way females feel about themselves during adolescence (Pipher, 1994). These are just some of the reasons researchers have become inspired to gather more information regarding the topic of adolescent females and risky behaviours.

Bronfenbrenner (1979) emphasizes the importance of environment on individual development in the ecological theory of human development. The *mesosystem* is described as interactions between the individual and domains such as family, school, and neighborhood peers. It is a system of microsystems interrelating, but at the same time all are dynamic and independently active. It is a relationship where both the individual and the domains (e.g., family and school) impact each other. This theorist postulates that the environment can influence the behaviours of the individual. Those individuals with weakly linked support systems may be more likely to engage in risky behaviours. The environment can act as a protective mechanism for the individual in regards to health. When discussing the importance of school and family on the development of children, Bronfenbrenner hypothesizes that

> "the developmental potential of a setting is increased as a function of the number of supportive links existing between that setting and other settings (such as home and family). Thus the least favorable condition for development is one in which supplementary links are either non-supportive or completely absent – when the mesosystem is weakly linked" (p. 215).

In view of this theory, adolescents who do not feel connected to or supported by family and school may be at greater risk for unhealthy behaviours. It would seem logical then to aspire to strengthen a variety of supportive areas for adolescent females, such as family school, and at the individual level, in order to increase teens' "developmental potential".

By taking a closer look at protective factors, such as family and school connectedness, we will be better able to pinpoint ways to nurture adolescent females so that they are empowered to make healthy life choices. Many aspects of family support, such as quality

of relationship, parental monitoring, trust, and communication have been found to influence adolescent sexual behaviour (Murray, 1996; McNeely, Shew, Beuhring, Sieving, Miller, & Blum, 2002; Huebner & Howell, 2003; Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003). Attachments to school, academic achievement and educational aspirations have also been found to impact sexual behaviour in youth (He, Kramer, Houser, Chomitz, & Hacker, 2004; Witwer, 1993; Small & Luster, 1994). Therefore, strengthening these domains, such as parent-adolescent relationships and connections with school will likely help to build resiliency in youth and promote healthy behaviours.

Gathering more information regarding the specific aspects of teen girls' risky sexual behaviour can also assist professionals in developing more general ways to effectively assist young girls through their transition to adulthood. Teen females report symptoms of depression more than double that of young men (Nolen-Hoeksema & Girgus, 1994). If counsellors aim to strengthen not only the domains of family and school, but also the individual, this may lead to increased resources for health. Zweig, Philips, & Lindberg (2002) found that individual psychosocial adjustment, school, and family domains are related to profiles of health risk behaviour. At the individual level, some of the ways counsellors may strive to find ways to strengthen teen girls' identity may be by exploring their unique qualities and connecting them within the community. Once adolescent females become aware of their strengths, they may become interested in investing in themselves, which may translate into healthy behaviours. Learning healthy ways to cope with stress will help add to teen girls' protective assets. A "strengths-based" approach is rooted in social constructivism where the importance of reconstructing the clients' view of themselves is emphasized (Sharry, 2004). By using this approach as a general guide with teen girls, professionals can not only help to foster teens' relationships with their families and school, but also teens' relationships with themselves. Graham (2004) states that,

> "one of the tasks they (teens) face throughout their teen years is to continue to like themselves, to understand themselves, to improve their understanding of others, to develop their talents, to remain energetic, and to think positively about the present and the future" (p. 83).

If families, schools, and other professionals can provide supportive environments where adolescents can thrive, young people may be better able to tap into their strengths. Perhaps strong ties to family and school combined with the development of a positive relationship with the self will provide greater barriers in order for health to reign.

Plan of Study

The purpose of this study was to determine which of five school-related factors best predicts the use of contraceptives at first intercourse and whether there is a relationship between parent-adolescent communication and sexual debut for adolescent females in rural Alberta. The two quantitative papers were intended for academic journals. The third paper was designed as a guide for professionals and caregivers and provides general suggestions that address issues relating to the sexual and health behaviours of adolescent females. A strengths-based counselling approach is presented. As we gain more insight into the factors that are associated with first intercourse for females, we as parents, educators, and counsellors, can continue to adopt creative ways to promote overall healthy behaviours in young women.

Research Questions

1. Which of the five school-related factors (grade point average, educational aspirations, attachment to school, weekly time spent studying, and weekly time spent on homework) introduced on the *Student Health Survey* (SHS), best predicts the use of contraceptives at first intercourse for adolescent females?

2. Is parent-adolescent communication regarding sex, related to sexual debut for adolescent females? Do those females who perceive communication with their parents about sex also delay age and report more contraceptive use at first intercourse compared to females who report no communication with parents?

3. After reviewing the results from these and other studies, in general, how can we aim to promote healthy behaviours in adolescent females? A strengths-based approach in counselling is presented as a guide for professionals and caregivers to provide resources for healthy behavioural development during adolescence and on through adulthood.

Participant and Instrument

Five hundred and twelve adolescent males and females from a town in rural Alberta, just outside of Edmonton, completed a questionnaire (Hess & Schnirer, 1996). There were a total of 238 males and 274 females who participated in the survey. The purpose of the study was presented to parents, school staff, and students, and they were informed that they could withdraw from the study at any time. Involvement in the study was voluntary and parents and students each signed for and gave their informed consent to participate in the study. Confidentiality was protected by directing students to refrain from writing their names on the surveys and to place each survey into an individually sealed envelope. Students were asked to answer honestly, and were free to skip any questions they did not want to answer. In 2003, ethical approval was granted by the University Of Alberta Faculties of Education and Extension Research Board (REB) approved the use of the data

from the 123 sexually active female participants for the purpose of this study. A total of 45% of the females responded that they were sexually active. Sexual activity was defined as "going all the way…i.e., with penetration). Therefore, data from 55% of the females (n=151) who responded that they had not yet engaged in sexual behaviour were not examined for the present study. The SHS (originally titled *Adolescent Sexuality Survey*) contains questions regarding health, family, school, and the sexual behaviours of adolescents (see Appendix A). This survey was created based on research by Fehlauer (1992) to further the research regarding adolescent sexual education (Hess & Schnirer, 1996).

Overview of Chapters

The five chapters in this thesis are as follows. In the first chapter, the nature of the problem is explained and a rationale for why this is a problem worth investigating is provided. A research plan is also presented. The next two articles, chapter two and three, are intended for journals and particular hypotheses are suggested. In chapter two, the researcher attempts to identify which of five school-related factors predict contraceptive use at first intercourse. Chapter three deals with whether parent-adolescent communication is related to age and contraceptive use at first intercourse. Chapter four was written by a colleague and me (Cathy Robinson and Jennifer Thomson - referenced alphabetically) based on research and practical experience working with adolescent clients and is intended for a broader range of adults. It focuses on providing parents, educators, and counsellors with general ways to empower young females in the areas of healthy behaviours. This chapter would be most beneficial as a popular press article so that adults who interact with teens on a regular basis could have access to these counselling suggestions. The last chapter is a summary of the results found, the limitations of this study, and the suggestions for future research regarding female adolescents, sexual behaviour, and counselling.

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Chapter 2 – Which School-Related Factors Predict the use of Contraceptives at First Intercourse for Adolescent Females?

Adolescent females who use contraceptives at first intercourse decrease the chances for unwanted pregnancy and sexually transmitted infections (STI's). It has been found that pregnancies tend to occur more often during primary sexual experiences (O'Donnell, O'Donnell, & Stueve, 2001). As well, using contraceptives during early sexual experiences is related to patterns of contraceptive use for later sexual encounters (Miller et al., 1998; Shafii, Stovel, & Holmes, 2003). Singh and Darroch (2000) state that the fallen teen pregnancy rates in Canada over the last quarter century can be attributed to social and economic changes. For instance, a higher value placed on educational achievement and on the attainment of higher education levels, has likely impacted childbearing in teens. Despite the reportedly high rates of contraception use amongst adolescents at first intercourse (80%) and the decline of teenaged pregnancy rates between 1980-1995, Canadian adolescents continue to become pregnant at high numbers when compared to other developed countries (Maticka-Tyndale, 2001). Early pregnancy is also linked with less chance of completing high school and continuing on to higher levels of education which increases the odds of these young families living in poverty posing other future risks and disadvantages (Manlove, Terry, Gitelson, Romano Papillo, & Russell, 2000). Rather than focusing primarily on the negative outcomes of risky sexual practices, researchers have become interested in resiliency and protective factors that help prevent youth from engaging in potentially unhealthy sexual behaviours.

Bronfenbrenner's (1979) theory of ecology for human development sees the individual as a dynamic system interrelating with other dynamic systems such as family, school, and peers. It is also a cumulative risk approach, in that, the more positive interrelations that exist between these domains (individual, family, school, peers), the more chances an individual will be supported and develop to their potential and vice versa for ecological weaknesses in these interrelationships.

The present study aims to examine ways in which the school domain may act as a protective factor when it comes to adolescent females' sexual behaviour. Previous data from a survey conducted with 123 sexually active females from rural Alberta will be analyzed to determine which of five school-related factors (GPA, educational aspirations, attachment to school, weekly time spent studying, and weekly time spent on homework) best predict contraceptive use at first intercourse. More detailed knowledge regarding the relationship between the school domain and adolescent females' sexual behaviour will enable educators, counsellors, and parents to respond more accurately to the needs of adolescent females. This area of research can be applied to the design of educational programs and counselling strategies that aspire to promote healthy behaviours in young people. For example, it may be beneficial if tools for academic success, such as study skills are introduced, so that those youth who perform poorly in school and who are at risk for early pregnancies and STI's can gain more practice and can become equipped with the academic skills they are lacking. There is a possibility that strong planning and executive skills in school can possibly be accessed and put to good use in other areas of

life, such as sexual behaviour. Gaining skills that promote academic success may also bring more hope for an academic future especially for those adolescents who may not believe in their academic ability.

Previous studies have examined ecological risks and assets and have included factors at the environmental, such as neighborhood characteristics, socioeconomic status (SES), school involvement, family connectedness, etc. Many studies focus on a combination of these environmental and individual factors to uncover information regarding adolescent sexual behaviour (Small & Luster, 1994; Billy & Brewster, 1994; Teitler & Weiss, 2000). This research has confirmed Bronfenbrenner's hypothesis that strong interrelations in the systems are related to positive development and demonstrate that environmental (e.g., neighborhood characteristics, school organization, socioeconomic status) and individual-level factors (e.g., religious affiliation and academic achievement) influence sexual risk-taking behaviours in teens. However, results from a study conducted by Teitler and Weiss (2000) indicate that neighborhood effects on the behaviour of adolescents have been overestimated and that school factors such as school environment have more impact on the sexual behaviour of young people.

Individual-level factors involving academic achievement and goals, such as grade point average (GPA), educational aspirations, and attachment to school, have often been linked to sexual risk taking in young people (He, Kramer, Houser, Chomitz, & Hacker, 2004; Witwer, 1993; Small & Luster, 1994). The purpose of this study is to examine the impact of school factors more closely in order to determine which ones can predict adolescent females' contraceptive use at first intercourse. The five school-related factors will include GPA, educational aspirations, attachment to school, weekly studying, and weekly homework time. Gaining clarity of the impact of these school factors on contraceptive use at first intercourse for adolescent females will assist parents, educators, and counsellors to better understand the relationship between these variables. Increased knowledge regarding assets during adolescence, such as school involvement, will help guide professionals to pinpoint positive preventative methods when working with this population with the aim of fostering the identity of youth and encouraging healthier decision-making when it comes to sex.

Fostering the relationship between adolescent females and school may inspire females to think about their future possibilities. Perhaps, this could be a way to protect females from taking sexual risks. Ungar, Molina, and Teran (2000) posit that when females are connected to school, such as when they perceive educational or career opportunities, they may want to protect their future possibilities to a greater extent than those who do not excel in school. The research demonstrates that adolescents, who exhibit a positive relationship with school, also act more sexually responsible by using contraceptives and delaying the age of first intercourse. For example adolescents who take less sexual risks often also excel in school with regards to grades (Billy & Brewster, 1994), report higher educational and career aspirations (Schvaneveldt, Miller, Berry, & Lee, 2004), and are often more attached to school (Witwer, 1993).

As discussed, school connectedness has been examined in the research by comparing grade point average, educational aspirations, and attachment to school with the sexual behaviour of teens. Factors such as weekly time spent studying and doing homework, can also be viewed as a reflection of school commitment and are likely associated with academic achievement. The author will attempt to pinpoint which of these five school-related factors best predicts adolescent females' use of contraceptives at first intercourse. This way, parents, educators, and counsellors can attend more specifically to those school factors that make a difference in the sexual behaviour of adolescent females. Finding ways to encourage females to invest in their academic "identity" may lead to a greater investment in their overall identity, including sexual health and other health-related behaviours.

Many research studies have shown that a relationship exists between academic achievement and sexual-risk taking behaviours in adolescence. Other researchers focus on attachment to school or educational and career aspirations. No studies that examine weekly studying and homework time were found. However, many people would likely agree that all of these school factors are interrelated and represent involvement in or connectedness with school. The following studies repeatedly suggest that there exists a relationship between school factors and adolescent sexual behaviour.

Literature Review: Academic Achievement, Educational Aspirations, School Attachment, and Sexual Behaviour

In a study by Holden and Nelson (1993), 128 females from two schools were surveyed. Pregnant females were recruited from an alternative high school designed for pregnant teens and the non-pregnant females were attending the high school where most of the pregnant teens had previously attended. Researchers found that pregnant females and non-pregnant females differed in many ways. The most significant differences were present in relation to school. Results demonstrated that the pregnant females were more likely to be performing poorly in school and were less likely to have used contraceptives than the non-pregnant teens when asked about previous sexual activity.

In another study, it was hypothesized that educational attainment ("at or above the grade level expected for her age") would be associated with reduced levels of sexual activity for both white and black females (Billy & Brewster, 1994). They proposed that those females who feel encouraged to succeed through education were more likely to perceive related risks posed by engaging in sex. Results indicated that educational attainment is a factor associated with decreased sexual behaviour.

A study with students, grades 8-12, examined which of six student "assets" could predict risk or health promoting behaviours. The students with the most assets were least likely to engage in seven risk behaviours, and were more likely to engage in three health promoting behaviours. Grades in school were found to be significantly related to all assets and were found to have the most impact on the behaviour of the participants in the study with regards to their behaviour, including whether or not they had engaged in

sexual activity (Murphey, Lamonda, Carney, & Duncan, 2004).

A survey of 1487 youth from a high school in the U.S. revealed that healthy behaviours were linked with higher educational achievement, when examining healthy lifestyle choices in adolescents (He, et al., 2004). Health behaviours included sexual activity behaviours such as number of partners in the past three months and contraceptive use or non-use. Teens' chances of making positive healthy decisions was found to increase by 55% if their GPA improved by one "ordinal" grade level.

Initiation of intercourse was found to be linked to academic achievement in a sample of 3000 seventh grade students from schools in New Jersey, participating in an intervention program for the reduction of HIV, named *Healthy and Alive!* Other psychosocial factors consistently associated with initiation of intercourse were gender, personal and peer norms, and substance use. The researchers explain how academic achievement may be an indicator of low attachment to school or lower family and community support (Santelli, Kaiser, Hirsch, Radosh, Simkin, & Middlestadt, 2004).

In a review by Kirby (2002) regarding the impact of schools and programs upon adolescent sexual behaviour, he states that there appears to be a difference between school drop-outs and those who stay in school. He explains that this difference appears to occur before they actually quit school and that quitting school increases sexual risk-taking among youth. It is worthwhile examining school variables that predict sexual behaviour in young people as they are found to be related to those teens that discontinue schooling at a young age. In a review of 300 studies to determine the risk and protective factors in young people Kirby (2001) also found that attachment to school was an important protective factor with regards to adolescent sexual risk-taking (contraceptive use, frequency of sex, initiation of sex).

A longitudinal study identifying risk factors for early pregnancy in 190 females with serious emotional disturbance aged 9-18 was conducted (Yampolskaya, Brown, Greenbaum, 2002). The one risk factor found to predict pregnancy was "dropping out of school". Over half of the pregnant teens in this study had dropped out of school prior to getting pregnant, likely an indication of their lower academic abilities or lack of school connectedness.

Similar results were found in a study by Manlove (1998) with Hispanic, White, and Black female teens, where attachment to school was significantly associated with evading pregnancy in adolescence. Many of the females studied had dropped out of school prior to their pregnancies. The researcher discusses the relationship between school engagement and educational and career goals. She states that those with lower educational aspirations may be lacking in their attachment to school and suggests that a potentially successful pregnancy prevention strategy would be to aim to connect girls with their schooling environments at an early age.

Manlove, Mariner, and Romano Papillo (2000) found that adolescent mothers who stayed in school, lived at home with their parents, and were involved in their education or a career were less likely to give birth to a second child during their teen years. Teen mothers who dropped out of school before they were pregnant with their first child were found to have a greater chance of having a second birth. These researchers discuss the importance of programs that aim to keep females in school as this may aid in preventing earlier and later births during adolescence.

Perhaps school belonging and attachment is at risk for those who have lower cognitive ability which has been found to associate with women giving birth at younger ages. In an analysis of a sample of youth from an American study of 12,686 women and men aged 14-22, poverty and low cognitive ability was linked with early childbearing. Shearer, Mulvihill, Klerman, Wallander, Hovinga, and Redden (2002) found that those women who had given birth before age 18 and who had a second birth before age 20 had significantly lower cognitive scores than their non-childbearing peers. As well, women with lowered cognitive aptitude initiated sexual activity at younger ages than their counterparts. These findings support Manlove's (1998) statement of the importance of fostering academic involvement at early ages in order to strengthen the academic component in females so that it acts as a protective factor against risky sexual behaviour in youth and young adulthood.

Similar findings were demonstrated in a study with 102 adolescent females from 11-20 years (Matson & Haglund, 2000). Participants were given an oral questionnaire and a reading test to determine whether or not they had a reading delay. A higher number of females who had been pregnant experienced greater reading difficulties than girls who had not become pregnant. Again, high academic achievement and strong reading skills may inhibit early pregnancy in adolescent females.

In an analysis of data from 1,142 teens, it was found that educational aspirations and positive attitudes towards school were strongly associated with early childbearing (Witwer, 1993). This author suggests that encouraging adolescents' school connections and inspiring students to aim to attend higher education may have "large indirect benefits in terms of reducing premarital childbearing and its associated social and economic costs" (p.190).

Educational goals were significantly related to Black teens' age at first intercourse in a longitudinal study with children and adolescents (Schvaneveldt, Miller, Berry, & Lee, 2004). In addition, interest in school was found to significantly relate to initiation age of sexual intercourse in White females. Overall across race and gender they found that teens with lower academic goals and achievement participated in sexual intercourse at earlier ages. They also discovered that sexual behaviour resulted in lowered interest in education and in school effort.

Another study examining a theory of adolescent decision making interviewed Latino and African-American pregnant teens (Gordon, 1996). Low academic skills and poverty

were found to predict teen pregnancy. These findings were the opposite of the usual explanations in the literature that pregnancy leads to dropping out of school and to poverty. It appeared that pregnancy subsequently followed academic achievement and poverty, rather than the reverse. Another surprising finding was that many of the teens had chosen to become pregnant and planned to keep their babies. Likely these pregnant teens' futures in regards to career and educational opportunities, had been lower than their non-pregnant peers, and this may have impacted their decisions to become pregnant.

Fourteen variables were examined by Small and Luster (1994) to determine whether they were associated with sexual activity in males and females. Twelve variables were found to differ between sexually active females and sexually inexperienced females. Of the twelve, school variables such as GPA and school attachment ("reporting that school is not meaningful or enjoyable") were included. Along with these school-related variables, concern regarding the ability to succeed in the future, were all found to be linked to sexual activity among females.

The studies described above demonstrate how school factors such as academic achievement, educational aspirations, and school connectedness are associated with the sexual health of adolescent females such as contraceptive use, age at first intercourse, and early childbearing. This study aimed to gather specific information regarding which of five school factors (GPA, educational aspirations, attachment to school, and weekly study and homework time) most significantly impacted contraceptive use at first intercourse for adolescent females. By pinpointing the school factors that are most influential when it comes to adolescent sexual behaviour, professionals and caregivers working with adolescent females can target ways to strengthen their academic "identity", especially for those who are likely to engage in risky sex and as a preventative measure for young females transitioning to adulthood. It is speculated that females who have confidence in their academic ability likely incorporate opportunities to follow educational and career paths. For instance, those with academic futures take fewer chances when it comes to pregnancy or other risky sexual behaviours that pose potential restrictions on their dreams (Ungar, et al., 2000).

The research has demonstrated that school-related factors are linked to the sexual practices of young people. However, identification of school factors that can actually predict specific sexual behaviours in youth has not been discovered in the current literature. This study proposed to take it a step further and examine which school factor (GPA, educational aspirations, attachment to school, weekly time spent studying, and weekly time spent on homework) best predicts adolescent females' contraceptive use at first intercourse. Gathering this information will enable caregivers and professionals to uniquely tailor their efforts with regards to teen girls and sexual health.

Method

Participants

The *Student Health Survey* (SHS) (originally titled the *Adolescent Sexuality Survey*) was completed by 512 students from two rural schools in northern Alberta (Hess & Schnirer, 1996). Two hundred and thirty-eight males and 274 females in Grades 9 to 12 (ages 14-18) participated in the survey. Overall, 45% of females in this data set answered "yes" to having had sexual intercourse. For the purpose of this study, only data from females who reported that they had engaged in sexual intercourse (total n=123) was examined. The mean age of the females was 17 years old. Data from the 55% of females who responded that they had not engaged in sexual intercourse were not analyzed for the present study.

Instrument

The SHS, a multiple-choice instrument that includes questions regarding background information, health-related behaviours, and school-related topics, was completed by the participants. The survey, based on research by Fehlauer (1992) regarding personal classroom and counselling experiences, was developed to further the study of adolescent sexuality (Hess & Schnirer, 1996). Data collected included information containing facts such as age at first intercourse and contraceptive use, and also included subjective information such as feelings towards school and sexual intercourse. For a more in-depth look at adolescent females' experience of first intercourse, I used questions that focused on females' school-related factors and contraceptive use at first intercourse. For this research paper, the following items and responses were used:

A) The **Five School-related** items included: (See Appendix A: Part 1 – Background Information, #14, 19, 20, 21, 23)

(i) Do you like school?

(1) I love school
(2) I like school more than most of my friends
(3) It's OK (average)
(4) I don't like school very much
(5) I hate school

(ii) How much time, on average, do you spend doing homework each week?

(1) None
(2) Less than one hour
(3) 1-2 hours
(4) 3-5 hours
(5) More than 5 hours

(iii) How much time, on average, do you spend studying each week?

(1) None
(2) Less than one hour
(3) 1-2 hours
(4) 3-5 hours
(5) More than 5 hours

(iv) What are your plans immediately after completing high school?

(1) Continue my education at a university
(2) Continue my education at a college with the intention of transferring to a university after one or two years
(3) Continue my education at a college (ie: NAIT)
(4) To get a job
(5) To travel
(6) I don't know yet

(v) What is your approximate grade average in school?

(1) Less than 40%
(2) 40-50%
(3) 50-65%
(4) 65-80%
(5) 80-100%

B) Items examined for this study regarding the topic of **first intercourse** included:

(i) Have you ever had sexual intercourse? (Going all the way…i.e., with penetration) (See Appendix A: Part 4 – Sexual Attitudes and Behaviour, #1)

(1) Yes (only those females who were sexually active were used for the present study)

(ii) Did you use any form of birth control when you had your first sexual experience? (See Appendix A: Part 4 – Sexual Attitudes and Behaviour, #11)

(1) Yes
(2) No

Ethics Approval and Procedures

Data was originally collected using the SHS to examine adolescent sexual and health-related behaviours (Hess & Schnirer, 1996). Written informed consent was obtained

from all participants and their parents. Participation was voluntary and students were assured that they could withdraw from the study at any time. The purpose of studying adolescent sexuality and health-related behaviours was explained to all students, parents, and staff, prior to administering the survey. For confidentiality purposes, students were instructed to answer the questions honestly and to skip any questions if honesty was ever at stake. Students were also instructed not to write their names on the survey in order for the survey to remain completely confidential. In addition, each student was to place his or her survey in an individually sealed envelope. The surveys were administered to all participants at the same time to prevent the students from discussing questions before participating in the survey. In 2003, ethical approval was granted by the University of Alberta Faculties of Research and Extension Research Board (REB) to utilize this previously collected data in order to gain more in-depth knowledge regarding adolescent females and their sexual behaviour.

Data Analysis

To determine whether a relationship existed between school-related items and contraceptive use at first intercourse reported on the SHS, certain items were recoded for analysis for the present study. Originally, the responses on the survey for the question regarding contraceptive use at first intercourse included: 1) I have never had sexual intercourse, 2) Yes, 3) No, 4) I don't remember, 5) I don't know (see Appendix A). For this study, data from females who reported being sexually active and those who reported using or not using contraceptives at the time of first intercourse were examined. Therefore, the above first response was omitted, along with the last two responses. Two participants responded that either they "did not remember" or that they "did not know" if they used contraceptives at first intercourse.

The dependent variable, "contraceptive use at first intercourse", was divided into two discrete groups for analysis as only the responses of either "yes" or "no" were used for the present study. Due to the fact that the dependent variable was discrete, logistic regression was used to analyze which school-related factors predicted contraceptive use at first intercourse for adolescent females who responded on the SHS.

Two of the five school-related variables were recoded for analysis for this study. These items were: "Do you like school?" and "What are your plans immediately after completing high school?" Both items originally included the response option of "other". However, in order to quantify these variables for statistical analysis, the response option where females could write in their own response, labelled "other", was omitted so that subjective responses did not have to be categorized. The remaining response options for these two recoded questions were included for this study. Possible responses for the question, "Do you like school?" were: I love school, I like school more than most of my friends, It's OK (average), I don't like school, and, I hate school. The response, "I love school" was ranked as the most attachment to school and the response, "I hate school" was representative of those females who were the least attached to school (see Appendix A).

For the item regarding plans after high school, possible choices included: 1) continue my education at a university, 2) continue my education at a college with the intention of transferring to a university after one or two years, 3) continue my education at a college (e.g. NAIT, Grant MacEwan), 4) to get a job, 5) to travel, 6) I don't know yet (see Appendix A). Females' with educational aspirations were those who included university or post-secondary education in their plans after high school. The response, "to continue education at a university" was ranked as the highest possible plan and the response, "I don't know yet" was ranked as the lowest possible plan, for the purpose of this study. Education and no education in future plans were also divided into two groups and compared. Original responses from the remaining three of the five school-related items from the survey were not recoded for this study's statistical analysis as all information reported on these three particular items was relevant for this study. They included: "How much time, on average, do you spend doing homework each week?" (none, less than one hour, 1-2 hours, 3-5 hours, more than 5 hours), "How much time, on average, do you spend studying each week?" (none, less than one hour, 1-2 hours, 3-5 hours, more than 5 hours), and, "What is your approximate grade point average in school?" (less than 40%, 40-50%, 50-65%, 65-80%, 80-100%) (see Appendix A). To investigate whether "educational plans" versus "no education in plans" were significantly related to contraceptive use at first intercourse, data from these two groups were also separated and then compared.

Table 2-1: Variables analyzed by using logistic regression

Variable	Variable Description
Contraceptive Use (Dependent Variable is discrete)	Responses to the question: "Did you use any form of birth control when you had your first sexual experience?" Yes=1, No=0
Homework	Responses to the question: "How much time, on average, do you spend doing homework each week?" None=1, less than one hour=2, 1-2 hours =3, 3-5 hours=4, more than 5 hours=5
Study Time	Responses to the question: "How much time, on average, do you spend studying each week?" None=1, less than one hour=2, 1-2 hours =3, 3-5 hours=4, more than 5 hours=5
GPA	Responses to the question: "What is your approximate grade average in school? Less than 40%=1, 40-50%=2, 50-65%=3, 65-80%=4, 80-100%=5
***Like/dislike school**	Responses to the question: "Do you like school? I love school=1, I like school more than most of my friends=2, it's okay (average)=3, I don't like school very much=4, I hate school=5
***Plans after high school**	Responses to the question: "What are your plans immediately after high school?" Continue my education at a university=1, Continue my education at a college with the intention of transferring to a university after one or two years=2, Continue my education at a college (e.g. NAIT, Grant MacEwan)) =3, To get a job=4, To travel=5, I don't know yet = 6

Note: *Indicates that these items are ranked with "1" as the highest, and "5" as the lowest and vice versa for the other three items. (See Appendix A)

The following tables reveal the relationship between the school-related factors and contraceptive use that were not found to be statistically significant. Raw scores and percentages are included in separate tables for each variable.

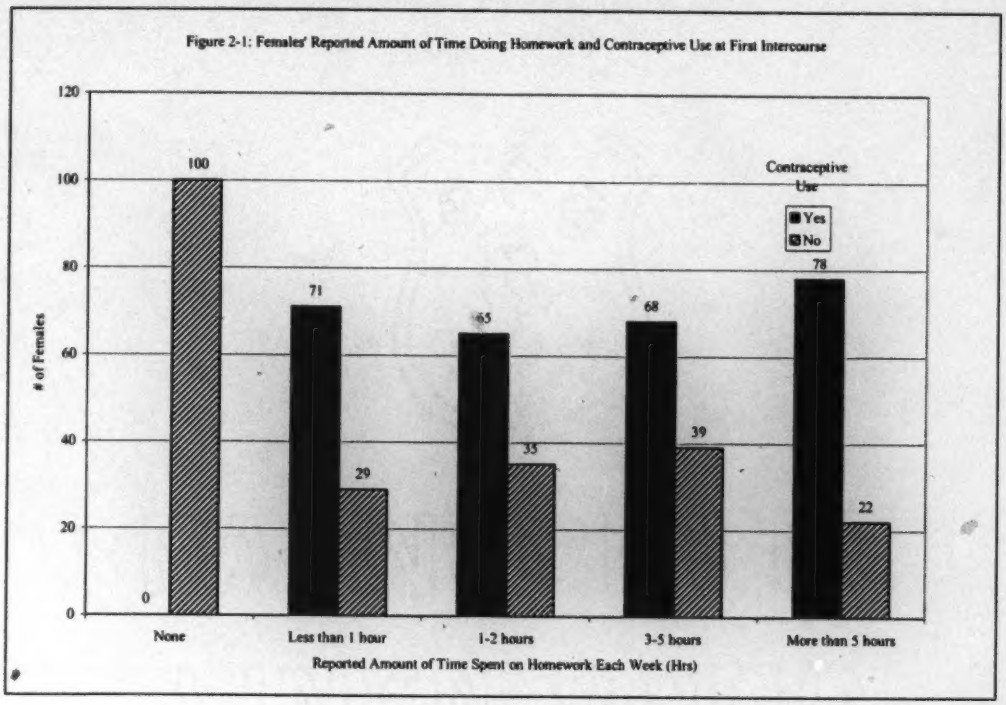
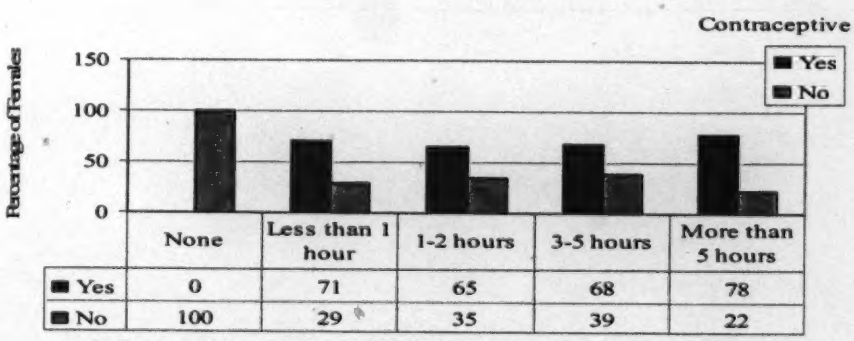


Figure 2-2: Females' Reported Amount of Time Doing Homework and Contraceptive Use at First Intercourse



	None	Less than 1 hour	1-2 hours	3-5 hours	More than 5 hours
Yes	0	71	65	68	78
No	100	29	35	39	22

Reported Amount of Weekly Time Spent on Homework (Hours)

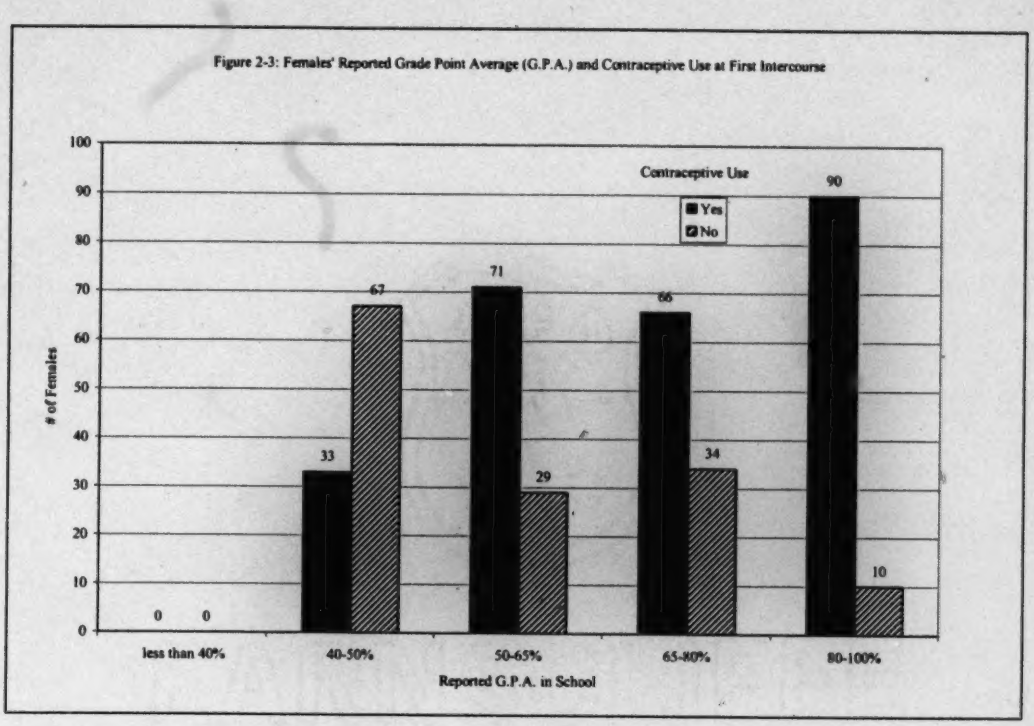
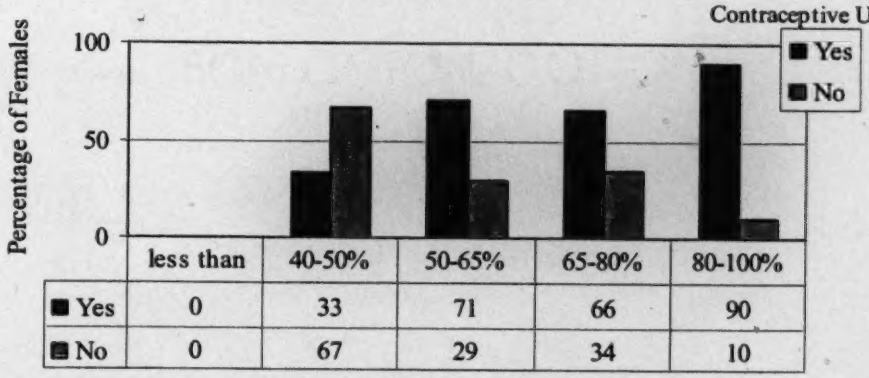


Figure 2-4: Females' Reported Grade Point Average (GPA) and Contraceptive Use at First Intercourse



	less than	40-50%	50-65%	65-80%	80-100%
Yes	0	33	71	66	90
No	0	67	29	34	10

Reported Grade Point Average (G.P.A.)

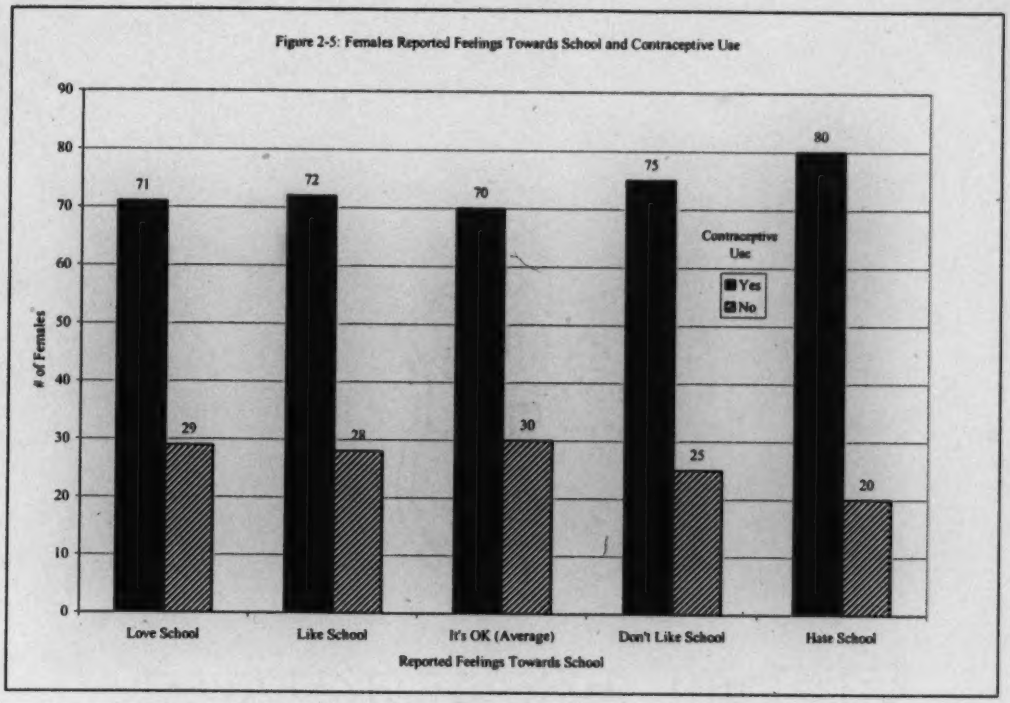
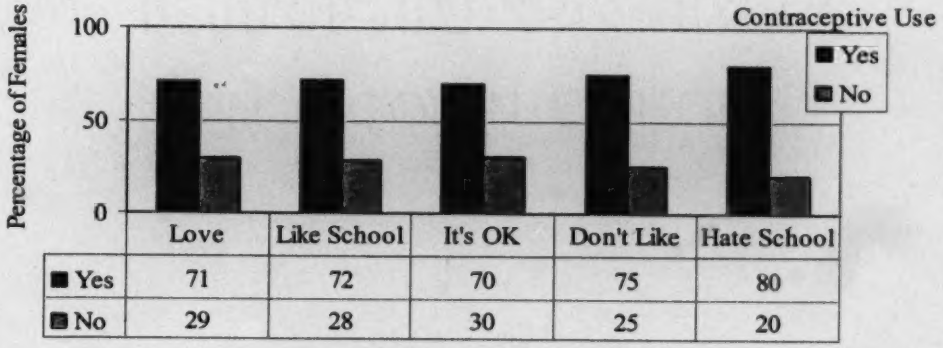


Figure 2-6: Females' Reported Feelings Towards School and Contraceptive Use at First Intercourse



	Love	Like School	It's OK	Don't Like	Hate School
Yes	71	72	70	75	80
No	29	28	30	25	20

Reported Feelings towards School

Figure 2-7: Females' Reported Plans after High School and Contraceptive Use at First Intercourse

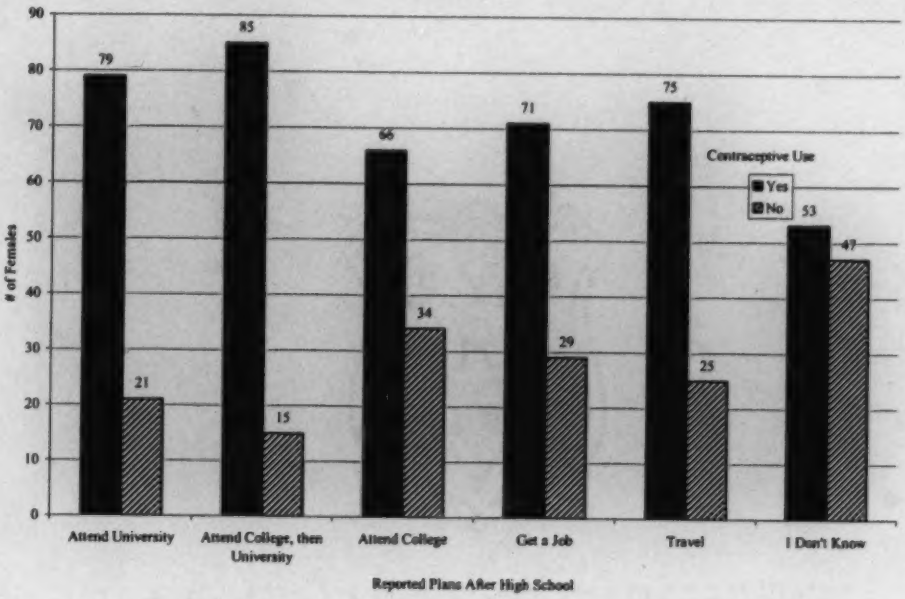
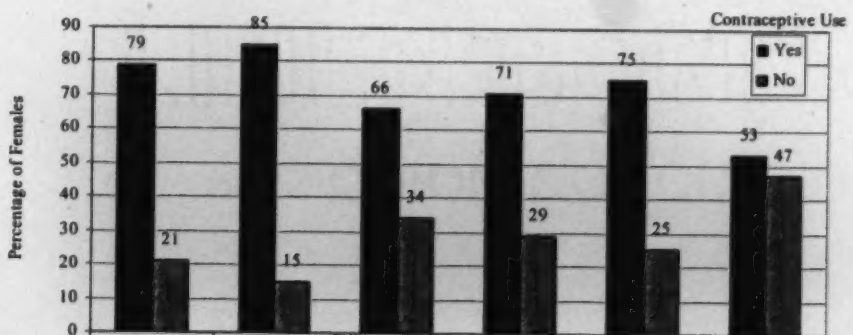


Figure 2-8: Females' Reported Plans after High School and Contraceptive Use at First Intercourse



	Attend University	Attend College, then University	Attend College	Get a Job	Travel	I Don't Know
Yes	79	85	66	71	75	53
No	21	15	34	29	25	47

Reported Plans after High School

Figure 2-9: Females' Reported Plans after High School and Contraceptive Use at First Intercourse

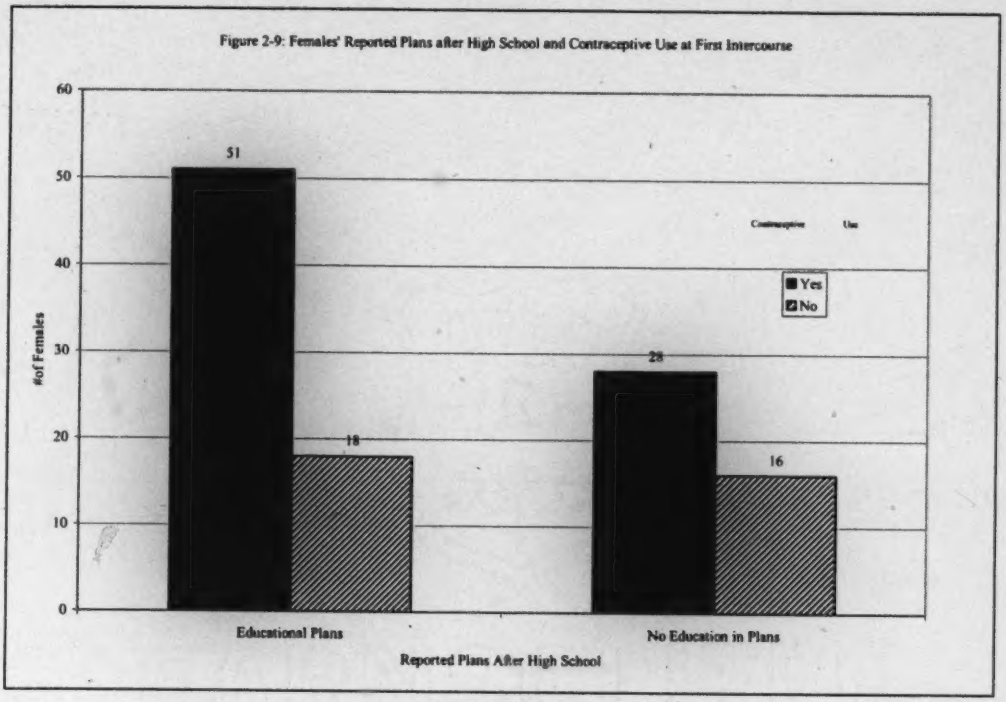
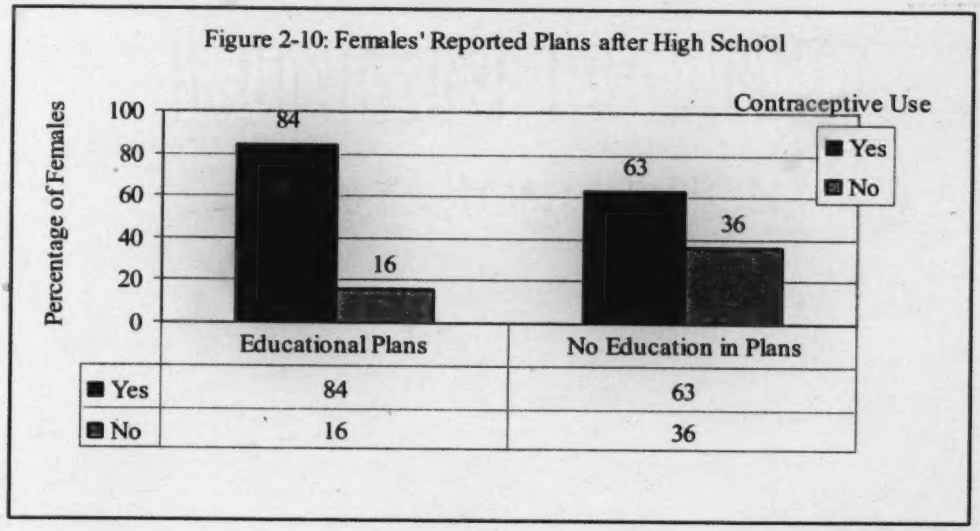


Figure 2-10: Females' Reported Plans after High School



Results

Logistic regression was used to determine whether five school-related variables on the SHS significantly predict contraceptive use at first intercourse. The logistic regression model is used to approximate which school-related variables most impact the discrete dependent variable, contraceptive use at first intercourse (Yes=1, No=0) (see Table 2-1 above for a description of the variables).

Table 2-2: Logistic Regression Results
Dependent Variable: Contraceptive Use at First Intercourse = Yes

Variable	Model 1: Coefficient (β)	Coefficient Exp (β)	Wald	Sig.
Constant	-1.972	.139	.764	.382
Study Time	.942 *	2.565	7.989	.005
Plans	-.235	.791	2.510	.113
Like/Dislike School	.394	1.483	1.720	.190
G.P.A.	.210	1.233	.305	.581
Homework	-.165	.847	.347	.556
Model Chi-Square [df]	14.106 [5]			.015

Note: The Wald statistics are distributed chi-square with 4 degrees of freedom.
*Indicates that the coefficient is statistically significant at minimum, the .05 level.

The results from the logistic regression model suggest that one of the five school-related variables is significantly related to contraceptive use at first intercourse. Weekly studying time significantly predicts contraceptive use at first intercourse for sexually active adolescent females who completed the SHS. These results suggest that sexually active females who report more studying time per week also more often report using contraceptives at first intercourse. The *Study Time* variable coefficient is positive and statistically significant at the $p<.05$ level (95% confidence level) with a Wald statistic of 7.989 ($Exp[\beta]=2.565$, $df=1$). The Model chi-square statistic reveals that the logistic regression model is significant at the .05 level. The four other school-related factors analyzed for this study were not found to significantly predict contraceptive use at first intercourse.

Figure 2-11: Females' Reported Studying Time and Contraceptive Use at First Intercourse

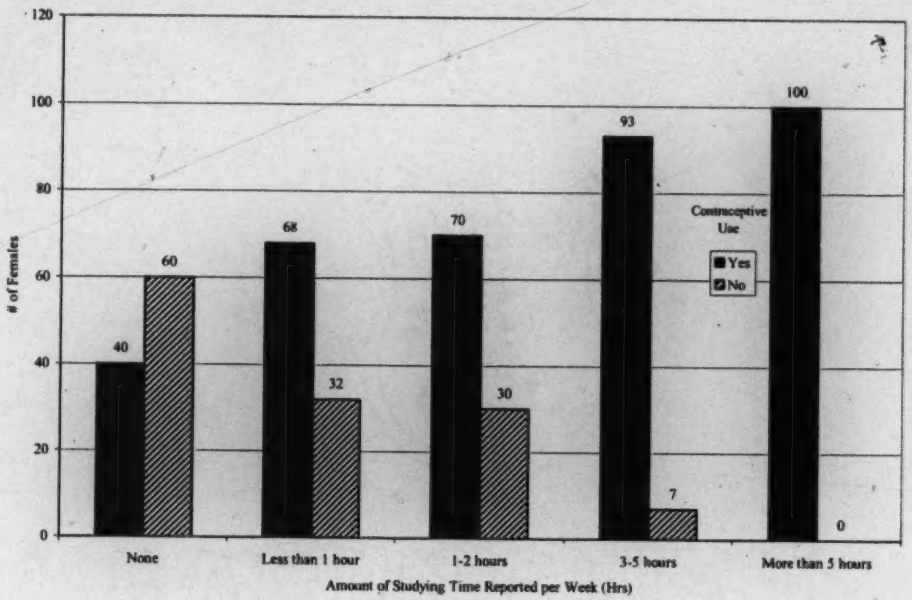
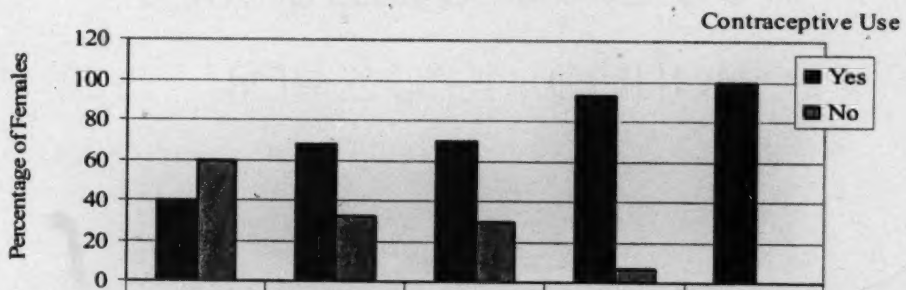


Figure 2-12: Females' Reported Weekly Studying Time and Contraceptive Use at First Intercourse



	None	Less than 1 hour	1-2 hours	3-5 hours	More than 5 hours
Yes	40	68	70	93	100
No	60	32	30	7	0

Amount of Studying Time Reported per Week (hours)

Discussion

Out of the five school factors tested, S*tudy Time* was the school factor pinpointed as significantly predicting the use of contraceptives at first intercourse for those females who participated in this study. Those females who reported more weekly studying hours also reported more contraceptive use at first intercourse. For this study, 45% of the females reported that they studied less than one hour per week and out of these females, 30-60% reported using no contraceptives at first intercourse. As well, for those who reported studying 1-5 hours per week, over 70% reported using contraceptives at first intercourse. The data showed that 100% of those females who reported studying more than 5 hours per week also reported using contraceptives at first intercourse. These results confirm other studies' results that school factors are related to adolescent sexual behaviour. At the same time, results from this study differed from the findings in the literature that demonstrate that GPA, school attachment, and educational aspirations significantly associate with contraceptive use at first intercourse (Billy & Brewster, 1994; Schvaneveldt, et al., 2004; Witwer, 1993). In addition, weekly time spent on homework was not found to be related to contraceptive use at first intercourse for the participants in this study.

It is logical to assume that the school factors for those young people who excel in school likely cluster. Those females who are high achievers also likely have high educational aspirations. However, results from this study suggest that a difference exists between school factors and how they are related to adolescent females' contraceptive use at first intercourse. We could suppose that those females, who study more often, have stronger planning or analytical skills. Females who study may also take greater initiative when it comes to school. Perhaps these females apply these skills across behaviours and use them even when it comes to sexual decision making, like contraceptive use at first intercourse. Though, some could argue that planning, analytical skills, and initiative are also required when it comes to doing homework, for academic achievement (G.P.A.), and educational aspirations. Further research examining these variables in detail is necessary in order to uncover more precise information regarding the relationship between school factors and sexual risk-taking. In addition, even though the four non-significant school-related factors did not evidently reveal a relationship with contraceptive use at first intercourse, it appears that there are trends that may be worthwhile discussing in order to further grasp the results from this study.

The non-significant results reveal that there exists a trend between GPA and contraceptive use at first intercourse for adolescent females (see Figure 2-2). In other words, females who reported a higher GPA also reported a high percentage of contraceptive use at first intercourse. Approximately 70% of females who reported a GPA between 50-80% also reported contraceptive use at first intercourse. For those females reporting a higher GPA of 80-100%, 90% reported using contraceptives at first intercourse. On the contrary, for those females reporting a lower GPA of less than 50%, almost 70% reported that they had *not* used contraceptives at first intercourse. However, it is important to bear in mind that overall, 69% of sexually active females reported using

contraceptives at first intercourse when examined on the GPA variable. In this study, contraceptive use is high for the females and this is logical when reviewing literature that reports the increase of contraceptive use over the past 15 years (Maticka-Tyndale, 2001). As well, it is important to remember that females in this survey are reporting present GPA and past sexual behaviour (experience of first intercourse). Therefore, females may have had a different GPA at the time of their experience of first intercourse and things may have been different for them while participating in the survey. This may have impacted the results as well. However, the trend revealed in this study does coincide with the findings from the literature. That is, females with lower GPA's who are also reporting lowered rates of contraceptive use at first intercourse may be a group that researchers and other professionals may want to target for furthering the design of preventative measures, as it is these females who may be at risk for early pregnancy and STI's as well as lowered educational status and future poverty.

Another interesting non-significant relationship in this study was *plans after high school* and contraceptive use. Though these two variables did not appear to be related, when examining the data, females who answered "I don't know" when responding to the question, "what are your plans immediately after high school?" were at risk for decreased contraceptive use at first intercourse. When examining those females who reported using contraceptives on this variable the number of females decreased almost 20% when they responded that they "did not know" their future plans (53%) compared to when they responded that they had a specific plan regardless if it was educational or not (ranging from 66-85% with the highest being those who reported university education in their future plans). As well, the number of females who responded that they did *not* use contraceptives rose when they reported that they "did not know" their future plans (47%) compared to those females who reported a specific plan (ranged from 15-34%). When "educational plans" were combined and compared with "no education in their plans", a trend was noted. Overall, females who reported that education was in their plans, also reported a high percentage of contraceptive use at first intercourse (84%) versus those females who reported no education in their plans (63%). In addition, the percentage of females who reported no contraceptive use at first intercourse was lower for those females who had planned for education in their futures (16%) versus those females who did not plan to continue their education after high school (36%). Even though in our results, the relationship between "educational plans" and "no educational plans" was not found to be statistically significant, we can speculate from this noted trend, form the information regarding contraceptive use for those females who "did not know" their future plans, and from findings in the literature that fostering the educational aspirations and the futures of young females is likely an important factor for reducing unwanted circumstances of unprotected and early sexual experiences.

The two variables that did not appear to relate with contraceptive use at first intercourse were *weekly homework time* and *feelings towards school*. Firstly, the variable of *weekly homework time* may not have related to contraceptive use like the variables, G.P.A. or weekly studying time, due to the way it was measured in this study. It could be that those females who complete homework more quickly are brighter or more intelligent than those

students who take a larger amount of weekly homework time to complete assignments. Therefore, asking females how many hours in a week they do homework may not be an effective way to determine whether or not they are excelling in school. Yet, it may be fair to ask how females who study are different from those females who do homework, but do not take the time to study. This may provide more information for why this variable came out as non-significantly related to contraceptive use. Secondly, even though the literature has demonstrated a relationship between the variable, *feelings towards school* and sexual behaviour, this may not have been an effective way to measure school attachment as the majority of females in this study answered that school was "O.K." (59%). This may be an indication that females' feelings towards school can be reflective of many aspects of school, including friends, teachers, environment, or activities, as well as achievement. This question may be more reflective of how the individual female perceived the question and what it means to her, which makes it difficult for the researcher to determine what exactly is being measured. Therefore, there may be logical explanations for why the variables of *weekly homework time* and *feelings towards school* emerged as they did.

If researchers focus specifically on those school factors that boost resiliency in adolescence, perhaps school counsellors and teachers can directly teach the skills students need so that academic achievement can act as even more of a protective factor with regards to risky behaviour. As educators, counsellors, and parents, it is important that we provide young people and teach them specific academic skills that can enable students to become successful in school. For instance, introducing actual techniques, such as remembering by "association" or "webbing" may help to develop in youth a variety of study skills in order to equip them with the skills they need to succeed in school. The aim of providing students with positive tools for learning would be to strengthen the school domain so that it acts as a supportive resource for youth. Strengthening positive resources in adolescence can help protect young people from potentially harmful life situations (Bronfenbrenner, 1979). Increased information regarding school and sexual behaviour in adolescence will lead to new ways to inspire learning and empower adolescent females to invest in themselves and protect themselves from potential risks.

Limitations

The literature is not extensively detailed when it comes to school variables. Knowledge regarding the details of the relationship between school factors and sexual health is lacking. For instance, no studies were found that had tested variables such as weekly time spent studying and spent doing homework with sexual behaviour in adolescence. Therefore, more information is needed to determine whether these results are generalizable to the study of females' sexual behaviour. This will assist professionals to determine whether not and how to augment *Study Time* and how this school factor could be used in programs designed to prevent sexual risk-taking and that aim to enhance adolescents' relationship with school.

Another limitation of this study was that data from this questionnaire was previously collected, therefore, information that could have been gathered to help explain the results from this study such as interviews with parents, teachers, and school counsellors regarding the females who used contraceptives and who take time to study, could not be collected. Future studies may benefit from collecting information from a variety of sources when dealing with the topic of adolescent female sexuality and the relationship with school. Due to the fact that only the one aspect of adolescent sex (contraceptive use) was examined, there may not be enough information to draw conclusions around this multi-faceted topic of adolescent sexual behaviour (Miller, Forehand, & Kotchik, 2000). As well, results may not be generalized to urban populations, as participants were from a small rural town just outside of Edmonton, Alberta. Therefore, results may have been impacted by the characteristics of this sample. For example, emphasis on the type of plans after high school may be different in a rural town than it is in an urban setting.

Suggestions for Future Research

Is it enough to know that school factors relate to adolescent females' sexual behaviour or do researchers need to gather more detailed information around these variables? Qualitative research with adolescent females may complement the quantitative findings, and provide more insight regarding the specific school factors that impact safe sexual choices of adolescent females. This way, researchers can also gain more in-depth knowledge regarding the personality characteristics of those females who do and do not protect themselves when engaging in sexual behaviour. As well, interviews or surveys with parents, teachers, and school counsellors will allow researchers to gain other perspectives on adolescent teens who have safe sex versus those having unprotected sex.

Results from these studies and others can lead counsellors and parents to identify effective ways to work with and foster the identity of adolescent girls. From a holistic viewpoint, it would be important to strengthen the many protective aspects of the lives of female girls, one being school, with the hope of building up resiliency. A deeper understanding of the protective factors is necessary in order for professionals and caregivers to create programs and counselling strategies that are responsive to the needs of adolescent females' and their sexual health.

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Chapter 3 –Parent-Adolescent Communication and Adolescent Females' Sexual Debut

Early sexual debut in adolescence has been linked to risky sexual behaviours. Multiple partners and sexually transmitted infections (STI's) are more often reported by teens who engage in sex at younger ages when compared to teens who delay first intercourse (Kost & Forrest, 1992; Santelli, Brener, & Lowry, 1998). Even though adolescents are now using contraceptives more often and pregnancy rates have fallen over the past fifteen years, females were found to be four times more likely than males to report being involved in a teen pregnancy and were half as likely to report consistent condom use (O'Donnell, O'Donnell, & Stueve, 2001). Trends in teenage fertility, between 1980-1995, indicate that the proportion of sexually active adolescents who engaged in sex by the age of 15 increased from 40% to 50%, and the age of first intercourse has declined (Manlove, Terry, Gitelson, Romano Papillo, & Russell, 2000). The researchers state that those teens taking sexual risks, like having sex at younger ages, are at higher risk for becoming parents by the age of 20. The consequences of risky sexual behaviours in adolescence have compelled researchers to examine adolescent sexual behaviour.

The emotional aspect of female development and sexual behaviour may be another reason to find ways to encourage teen girls to delay age at first intercourse. Adolescent females have been found to report feeling "too young" regarding their age of initiation of sexual behaviour and report more negative feelings regarding first sexual experiences than males (Cotton, Mills, Succop, Biro, & Rosenthal, 2004; Hess, Chan, & Denkaus, 2002). Further information regarding adolescents who engage in risky sex, such as sex at earlier ages, will also assist professionals and caregivers in finding ways to prevent the distressing emotional consequences of risky sexual behaviours.

In the ecological theory of human development, Bronfenbrenner (1979) emphasizes the importance of environmental supports for the healthy development of the individual. The interaction between the individual and their family and school environments are especially impactful for children and adolescents as these are the main environments they encounter. In this theory, it is hypothesized that the stronger these areas are for adolescents, the less they will engage in risky behaviours. Thus, adolescents who engage in risky behaviours such as substance use, delinquency, sexual risk taking, etc., likely lack in supports when it comes to these domains. Family influence may be especially important for females due to the socialization factors. For example, in a study comparing adolescent males and females, family factors were more of a predictor for females' sexual attitudes, whereas, for males it was individual factors that influenced attitudes regarding sex (Werner-Wilson, 1998). Therefore, when examining adolescents and sexual behaviours it may be worthwhile to take into account domains such as family and school, as research regarding these environments and how the individual is interrelating within this environment may reveal more information regarding the behaviour of adolescents.

This study will examine how aspects of the family domain may be related to adolescent females' sexual behaviours. More specifically, adolescent females' reported perception of parent-adolescent communication regarding sex and whether it relates to timing of first intercourse and to contraceptive use at first intercourse will be investigated. It is hypothesized that adolescent females who perceive communication with parents regarding sex will delay age of intercourse and will report more contraceptive use at first intercourse compared to those females who report no communication with parents. Responses from 123 sexually active females from rural Alberta were used in this study. If parent-adolescent communication regarding sex is related to adolescent females' sexual behaviour, educators and counsellors may be encouraged to take a closer look at the development of communication skills and the relationship between parents and teens.

Several aspects of the family domain, such as quality of relationship, parental monitoring, trust, and communication have been found to be associated with adolescent sexual behaviour (Murray, 1996; McNeely, Shew, Beuhring, Sieving, Miller, & Blum, 2002; Huebner & Howell, 2003; Borawski, Ievers-Landis, Lovegreen, & Trapl, 2003). When specifically examining parent-adolescent communication, Fay and Yanoff (2000) reviewed results from an annual youth conference and found that teens reported that their peers were easier to approach when it came to discussing sex and that the majority of them felt that it was an adult's responsibility to approach them regarding sex education. As well, teens stated that they sensed that adults felt uncomfortable talking to them about sex. What teens stated that they really wanted was for parents to approach them and, "good dialogue with parents, without fear of judgement or punishment" (p.171). However, it seems that the study of parent-child communication about sex has encountered difficulties due to methodological problems (Miller, 2002). Many parents and adolescents report differences in perceived timing and content of communication and therefore, results from these studies vary.

In order to avoid this variance and rather than investigating amount, timing, or content in degree, the presence or absence of female adolescents' perceived communication with parents regarding sex and whether this is related to sexual debut for teen girls is studied in the current research. If an association is made, it will confirm previous findings that describe the family domain as a protective factor with regard to sexual behaviours in adolescence. The following studies have found that sexual behaviour is associated with parent-adolescent relationships in the areas of parental monitoring, trust, communication, and quality of relationships. Many of the current studies examine the relationship between maternal caregiver-to-adolescent communication regarding sex and some studies compare both parents' communication with adolescents. These will be presented in the following paragraphs for review.

Literature Review: Research Studies Reporting a Relationship Between Parent-Adolescent Relationships and Teen Sexual Behaviour

In 1996, data from 233 single African American females between the ages of 15 and 21

was taken from the 1988 National Survey of Family Growth to examine ecological factors and coital timing (Murry, 1996). Discriminant function analysis was performed to determine if parent-adolescent communication regarding sex could predict the timing of first intercourse for middle-class African American adolescent females. Parent-adolescent communication regarding contraception and STI's, along with other factors such as living with two parents, and increased knowledge regarding sex, were found to be related to females who delayed first intercourse until 18 years and older. Results from this study suggest that adolescent females who engage in discussions with their parents regarding sex engage in sexual behaviour at later ages.

A 10-year longitudinal study conducted by Karofsky, Zeng, and Kosorok (2000), found that those adolescents who perceive better communication with parents are less likely to have sex. Adolescents between the ages of 12 and 21 years (n=203) were used for this study. Their level of communication with parents was compared after they were divided into a virgin and non-virgin group. Non-virgins more often perceived lower communication with their fathers and mothers than virgins who perceived higher communication with either their father or mother. As well, good communication with mothers was more often associated with less risk of adolescents engaging in sex.

Similar findings were reported in a study examining mother-adolescent relationship and timing of first intercourse (McNeely, et al., 2002). Data from the National Longitudinal Study of Adolescent health was used. Female adolescents aged 14 and 15 transitioning from virgins to non-virgins reported that their relationship with their mother, mothers' disapproval of sexual intercourse, and mothers' frequency of communication with friends' parents were related to later sexual behaviour in females but not males. Even though discussions regarding sex were not examined in this study, the results indicate that the perceived mother-daughter relationship and the communication of mothers' values regarding sex had an impact on timing of first intercourse.

Parent-adolescent sexual risk communication was also examined for 250 African American and Caucasian female adolescents (Hutchinson & Cooney, 1998). Telephone interviews were conducted with the teen girls and their caregivers. Low to moderate rates of communication were reported, the lowest being father-adolescent communication regarding sex. The majority of the females (97%) desired more information from their mothers on a sexual topic and a high number (87%) desired further information from their fathers. The females who reported higher rates of parent-adolescent sexual risk communication also reported higher self-efficacy when it came to condom use, and greater likelihood of communicating with partners regarding their past sexual relationships and STI's. Again, this study demonstrates that parent-adolescent communication about sex is associated with females' sexual behaviour.

In another study, maternal figure-to-daughter discussions regarding pregnancy were found to be associated with negative attitudes towards pregnancy for 373 African-American female adolescents between the ages of 14 and 17 (Jaccard, Dodge, & Dittus,

2003). When mothers or female caretakers communicated to their daughters about the negative consequences of pregnancy and that they disapproved of pregnancy in adolescence, their daughters reported more negative views of pregnancy. As well, when these females reported a higher level of relationship satisfaction with their mothers they also reported more negative attitudes towards pregnancy.

Another study found that when mothers communicate with their daughters regarding sexual risks, they can have a positive impact on sexual behaviours in adolescence (Hutchinson, Jemmott, Jemmott, Braverman, & Fong, 2003). Two hundred and nineteen sexually active females aged 12-19 were studied to examine HIV-related sexual risk behaviour in an inner-city population. Number of male partners, frequency of sex in the past three months, and unprotected sex was reported along with mother-daughter communication regarding sex. Higher levels of mother-daughter communication was related to fewer episodes of sexual intercourse and less unprotected intercourse, but was not significantly associated with number of sexual partners.

Pick and Palos (1995) compared 1257 adolescent females aged 12-19 in Mexico City. Communication with mothers regarding sex, perceived family relations, and premarital pregnancy of immediate family members were some of the variables examined along with the sexual activity of the girls, such as contraceptive use, age at first intercourse, and pregnancy. For females between the ages of 16-19, those who had the most communication with their mothers regarding sex, did not have a sister who had been pregnant in adolescence, and whose mothers did not experience a premarital pregnancy, were least likely to engage in sexual activity at this age. Those females who had spoken with their mothers about sex were also found to use contraceptives and to have the lowest rates of pregnancy. These findings provide support for the notion that parent-adolescent communication regarding sex can positively impact the sexual activity of adolescent females.

A study with 214 late adolescents between the ages of 18 and 21 years, found that *timing* of parent-adolescent discussions regarding sex was related to sexual risk-taking behaviours more than *amount* of communication (Clawson & Reese-Weber, 2003). Adolescents who reported "on-time" discussions (discussed sex prior to the initiation of sexual intercourse) with mothers and fathers reported delays in onset of first intercourse. Even though reported amount of communication with parents was not found to significantly relate to sexual risk taking in adolescents, timing of communication was found to be related to timing of intercourse. These authors suggest that timing of parent-adolescent communication regarding sex be examined in more depth.

In a study by Hutchinson (2002) both timing and amount of sexual risk communication with parents was measured for 234 female adolescents. General communication with parents was found to predict sexual risk communication. Adolescents who reported communicating with parents about sex prior to engaging in intercourse and those who reported more general communication with their fathers also reported less risk of

initiating sex. Communication about sex and condom use, and general communication with mothers preceding sexual behaviour was significantly associated with greater condom use for these females. To summarize, early parent-adolescent discussions about sex was related to later age of first intercourse and increased condom use.

Female and male adolescents aged 13-15 were interviewed to determine the influence of parent-adolescent communication and peer communication on sexual behaviour and values (Diiorio, Kelley, Hockenberry-Eaton, 1999). Content of communication was examined specifically in this study. It was found that adolescents who spoke with their mothers about a wider variety of sexually-related topics were less likely to initiate intercourse and were more likely to adopt "conservative" attitudes regarding sex. It seems that content of communication with parents about sex matters for teens when it comes to their sexual behaviour.

A study investigating the process and content of sexual communication with adolescents found that both of these variables are associated with sexual risk-taking behaviour (Dutra, Miller, and Forehand, 1998). Focus groups regarding sexual communication with parents were conducted with 907 Black and Hispanic youth between 14-16 years. Adolescents reported that they more frequently discussed with their mothers than their fathers, topics regarding sex. They found that the frequency of sexual risk-taking decreased as the process of the sexual discussions with the mother became more open and receptive. Again, a link between maternal communication about sex and sexual behaviour in adolescence is revealed.

In a study by Huebner and Howell (2003), parental monitoring was found to be associated with sexual risk taking in teens. Males and females (n=1160) from 7^{th}-12^{th} grade were found to take less sexual risks when parental monitoring was high. These authors discuss how adolescent disclosure and parental communication is likely closely related to parental monitoring. However, frequency of communication between teens and parents was not found to relate to sexual risk taking in this study. It is suggested that when examining parent-adolescent communication, it may be worthwhile to include more information regarding content, timing, and style of communication about sex in order to gather more information on this topic. These results confirm the above study by Clawson and Reese-Weber (2003), where timing of discussions associated more with teens' sexual behaviour than amount of communication.

Parental monitoring, parental trust, and unsupervised time were measured with sexual behaviour in 692 male and female teens between 9^{th} and 10^{th} grades in six high schools (Borawski, Ievers-Landis, Lovegreen, and Trapl, 2003). Parental trust was found to be much more important for females than males. Females who perceived higher levels of trust from parents tended to report lower sexual activity and lower rates of substance abuse. As well, females who reported higher levels of unsupervised time demonstrated more proactive sexually safe behaviours such as carrying condoms, and refusing sex if condoms were unavailable, but also had increased sexual behaviours and prevalence of

substance abuse. Again, these results demonstrate that the parent-adolescent relationship impacts the sexual activity of adolescent females.

Studies that examined parent-adolescent relationships and sexual behaviour support the notion that family connections impact the behaviours of adolescents. Those adolescents, who perceive supportive relationships with parents in areas such as communication, monitoring, trust, etc., behave in healthier ways when it comes to sex. This study proposes that those adolescent females who perceive some communication with their parents regarding sex, will report engaging in first intercourse at later ages than those females who perceive no communication with parents about sex.

Method

Participants

Males and females from two rural schools in northern Alberta completed the *Student Health Survey* (SHS), originally titled the *Adolescent Sexuality Survey* (Hess & Schnirer, 1996). There were a total of 512 participants, 238 males and 274 females in grades 9 to 12. In 2003, the University of Alberta Ethics Committee, Faculties of Education and Extension Research Board (REB), approved use of the data from the sexually active female participants (n=123) in order to further explore female adolescent sexuality. Almost half of the females who completed the survey answered "yes" to having had sexual intercourse (44%). Within this sub-sample, most of the females were 17 years old with participants ranging in ages 14-18.

Instrument

The SHS used for the present study, included information relevant to adolescent sexuality such as age at first intercourse, contraceptive use, and dating relationships. Relationships with parents were also explored. This survey was created by Hess and Schnirer (1996) to continue research with adolescents similar to Fehlauer's (1992) research with adolescents in the areas of education and counselling. The questionnaire included multiple choice questions, fill in the blanks, and additional space was provided at the end of the survey so that adolescents could comment on any of the topics presented.

For the present study, the data from the following survey questions were analyzed to determine whether parent-adolescent communication regarding sex, age at first intercourse, and contraceptive use at first intercourse are significantly related:

A) Parent-adolescent communication regarding sex: (see Appendix A: Part 1 – Background Information, #13)

i) Have you ever talked to your parents about sex?

(1) Yes, a great deal
(2) Yes, a bit
(3) No, not at all

B) Sexual information was taken from the following items on the survey for this study:

(i) Have you ever had sexual intercourse? (Going all the way…i.e., with penetration) (see Appendix A: Part 4 – Sexual Attitudes and Behaviour, #1)

(1) Yes (only those females who were sexually active were used for the present study)

(ii) How old were you when you first had sexual intercourse? (see Appendix A: Part 4 – Sexual Attitudes and Behaviour, #4)

(1) 11 or younger
(2) 12
(3) 13
(4) 14
(5) 15
(6) 16
(7) 17
(8) 18

(iii) Did you use any form of birth control when you had your first sexual experience? (see Appendix A: Part 4 – Sexual Attitudes and Behaviour, #11)

(1) yes
(2) no

Ethics Approval and Procedures

Data was collected with the intention of examining adolescent sexual and health-related behaviours. The researchers explained the purpose of the study to students, parents, and staff at two rural high schools. The adolescents and their parents each consented to their involvement in the study by filling out an informed consent form. Each participant was advised that they could discontinue participation at any time during the study. Students were also informed to skip any questions in the questionnaire if they felt they could not

answer the questions honestly. In order to keep the identities of the participants confidential, students were not to write their names on the survey and each survey was placed in an envelope sealed by the participant at the conclusion of the survey. Students completed all questionnaires at one time so that students would not influence each other's answers. Ethics was then approved by the University of Alberta's Faculties of Education and Extension Research Board (REB) in 2003, to use the data gathered from the sexually active females to further examine adolescent females and sex.

Data Analysis

Only females who reported being sexually active were used for this study. The other items used from the questionnaire were recoded for the present study. The question exploring parent-adolescent communication regarding sex was recoded into a dichotomous variable to examine those females who felt that they had, in the past, communicated with their parents regarding sex and those who did not. Originally responses to the question, "Have you ever talked to your parents about sex?" included: Yes, a great deal; Yes, a bit; and, No, not at all (see Appendix A). Females who responded that they did communicate with their parents a "great deal" and "a bit" were grouped together into the "yes" group. Therefore, any communication that the teens had with their parents was grouped as "yes", regardless if it was "yes, a great deal" or "yes, a bit". Females who responded that they had not communicated at all were categorized into the "no" group.

To examine age and contraceptive use at first intercourse, responses had to be recoded for statistical analysis. There appeared to be an error on the original survey in the list of responses provided for the question asking, "How old were you when you first had sexual intercourse?" The ages provided in the choice of responses for this question began at age "11 or younger" and continued up to "18" years of age. The last age option was then stated as "10 or older". Due to the continuous nature of the responses on this item, the author assumed that the last possible response choice was intended as, "18 or older", rather than the response provided on the survey which read, "10 or older". Therefore, all of the responses stating "10 or older" were omitted for this study (see Appendix A). A one-way ANOVA was performed in order to determine whether a significant relationship existed between parent-adolescent communication regarding sex and age at first intercourse.

Responses were also recoded for the variable, contraceptive use at first intercourse. Originally, responses included: "I have never had sexual intercourse", "yes", "no", I don't remember", and "I don't know". This study aimed to examine whether or not females practiced safe sex, therefore, only the responses "yes" and "no" to contraceptive use were used for this study. Chi Square analysis was performed to investigate whether a significant relationship existed between parent-adolescent communication regarding sex and contraceptive use at first intercourse.

Results

A one-way analysis of variance (ANOVA) was used to analyze whether a statistically significant relationship existed between parent-adolescent communication and age at first intercourse for sexually active adolescent females. The analysis was significant, $F(1, 120)=6.67$, $p<.05$. Females who reported that they had communicated with their parents regarding sex also reported engaging in sexual intercourse at a later age ($M=15$, $SD=1.41$) than those females who reported that they had not communicated with their parents about sex ($M=14$, $SD=1.19$). (Raw scores and percentages are provided in Figures 3-1 and 3-2).

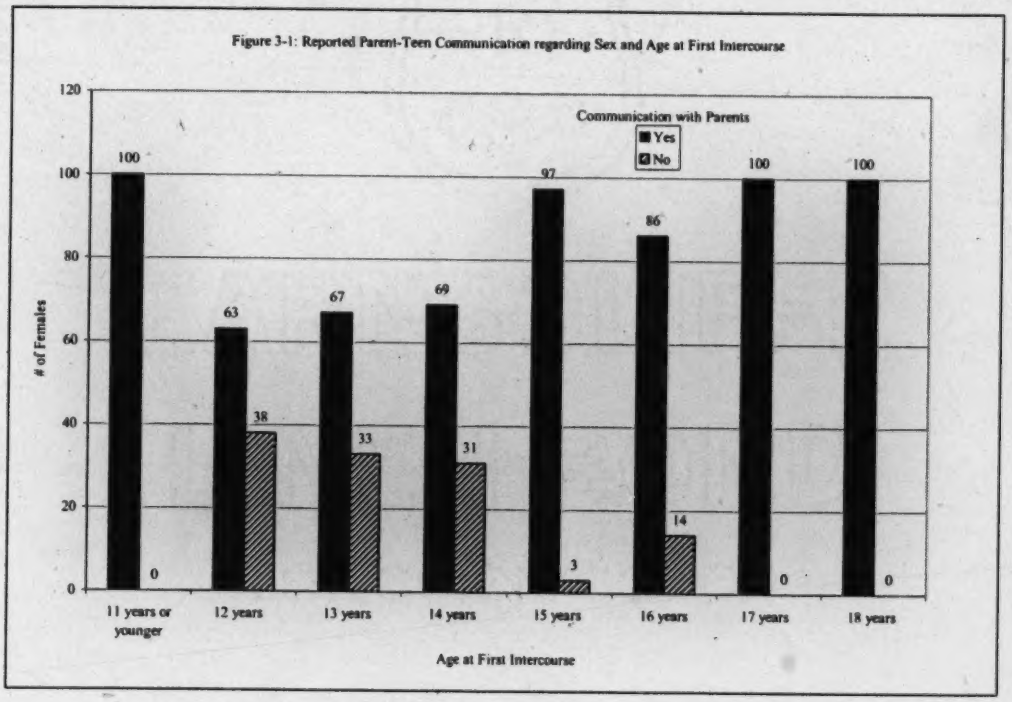
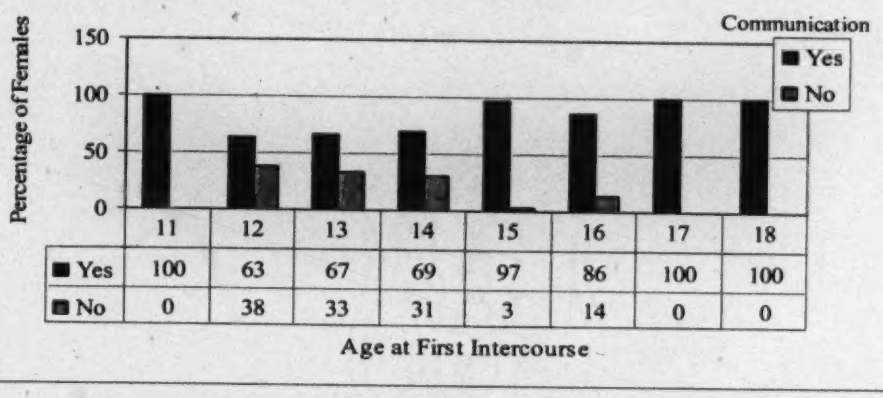


Figure 3-2: Reported Parent-Teen Communication regarding Sex and Age at First Intercourse



	11	12	13	14	15	16	17	18
Yes	100	63	67	69	97	86	100	100
No	0	38	33	31	3	14	0	0

A Chi-Square analysis was used to determine whether there is a statistically significant relationship between parent-adolescent communication and contraceptive use at first intercourse (n=70) (see Figure3-3). There were a high number of adolescent females who reported they had both communicated with parents about sex and that they had used contraceptives at first intercourse. However, there was not a significant difference between females who reported communication and contraceptive use when compared with those females who reported no communication and no contraceptive use at first intercourse, x^2 (1, N=123) = 1.89, p>.05). (See Figure 3-3 and 3-4)

Figure 3-3: Reported Parent-Teen Communication regarding Sex and Contraceptive Use at First Intercourse

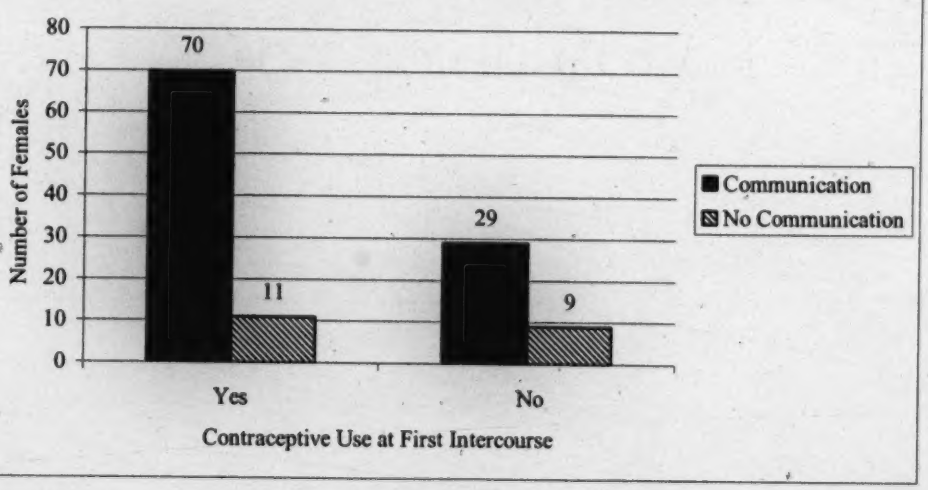
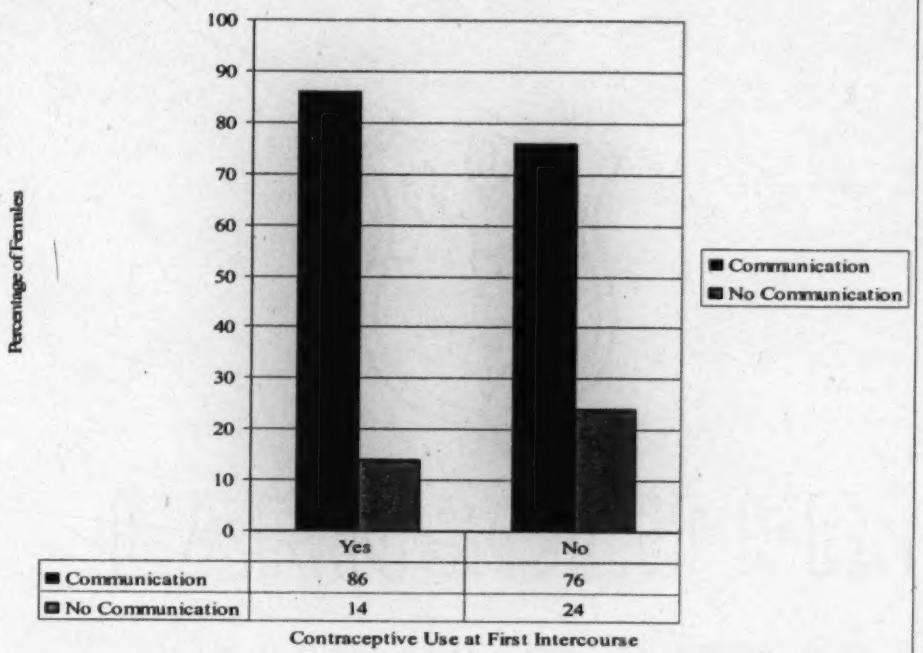


Figure 3-4: Parent-Adolescent Communication and Contraceptive Use at First Intercourse



Discussion

Ecological theory of human development and the above studies support the notion that the "family" domain, such as the quality of the parent-adolescent relationship and a supportive home environment, can act as a protective factor against risky behaviour in adolescence. Many research studies have found support for the relationship between teen sexual activity and parental involvement. A variety of aspects of the parent-adolescent relationship, such as parental monitoring, perceived parental support, trust, and communication have been found to associate with adolescent sexual behaviour. More specifically, when examining parent communication regarding sex, studies have often focused upon perceived timing, amount, or quality of parent communication regarding sex. The purpose of this study was to determine whether a significant relationship existed between some or no perceived parent-adolescent communication regarding sex and adolescent females' first sexual experience.

By comparing some or no perceived parent-adolescent communication with age at first intercourse and contraceptive use at first intercourse, results from our study confirmed previous findings that the parent-adolescent relationship can act as a protective factor for teenaged girls and sex. For example, the results from this study found that those females who perceived some communication with their parents regarding sex, reported delays in their age at first intercourse when compared to those females perceiving no communication. The majority of females in this study reported that they had their first intercourse at the age of fifteen and these results are also consistent with results found in a recent study conducted by Hess, Chan, and Denkhaus (2002). In addition, results from the present study are consistent with hypotheses from ecological risk factor theory and other studies that suggest that parental involvement influences adolescent sexual behaviour. However, contraceptive use was not significantly related to parent-teen communication. It was reported that 86% of those females who communicated with parents also reported that they used contraceptives at first intercourse. In addition, 82% of females reported that they had communicated with parents indicating that parent-teen communication is frequent, but is it always effective? Even though both communication and contraceptive use was reportedly high amongst these sexually active females, it may be beneficial for researchers to examine other aspects of parent-adolescent communication, such as content, timing, frequency, and quality of communication in order to further examine these and other results. It seems equally important to remember that though there are a high number of females communicating with parents and who are using contraceptives at first intercourse, there exists a small population of females that are engaging in sexually risky behaviours. By examining females who engage in both risky and healthy sexual behaviours and by gathering further information regarding the relationship between parent-teen discussions about sex and teen sexual behaviours, professionals and caregivers can further their understanding of the needs of these adolescent females. As the findings demonstrate, strengthening the relationship and the communication between parents and adolescents will enhance supports and decrease the odds of engaging in risky behaviours.

Further research examining other aspects of communication may be necessary to determine which factors are most influential when it comes to adolescent females and sexual behaviour. If researchers aim to determine the specific aspects of parent-adolescent communication we may be better able to find ways to protect youth from the consequences of risky sexual behaviours. If researchers can determine specific ways to strengthen the "family" domain, this may enhance sexual resiliency in adolescence, preventing many unwanted pregnancies and other consequences of risky sex. It is also important to consider that young females will likely find information regarding contraception and other sexually-related information from sources other than parents, such as from other family members, their peers, sexual education classes, media, etc. This is a likely explanation for these females' reportedly high use of contraception at first intercourse (86%) was not found to be related to parent-teen communication. However, it is interesting to note that there was a slight downward trend in contraceptive use when females reported no communication with parents (76%). Conversely, the percentage of

females who reported communication and no use of contraception at first intercourse (14%) was slightly lower than those females who reported no communication and no contraceptive use at first intercourse (24%). Even though communication and contraception was not found to be statistically significant, a slight trend was noted.

Limitations

Due to the fact that data from this questionnaire was previously collected, the author could not collect more information from participants and their families regarding communication and sex. Examining factors such as the timing and content of discussions may have provided additional information about how parent-teen communication can impact age at first intercourse and could expand upon the results found regarding contraceptive use. It would be interesting to know if those females who had delayed intercourse and who reported some communication with parents had also experienced discussions prior to the onset of intercourse and this is a limitation of this study for the information of timing of discussion(s) is unknown. As well, asking parents and teens about the content may determine whether or not contraceptive use was ever discussed. Including parents in interviews on their perceptions of communication with adolescents would have provided more information and another angle to the study. In the future, collecting information from both the adolescents and their caregivers may benefit the study of adolescent female sexuality and communication with parents regarding sex. Examining a range of aspects of adolescent sexual behaviour, such as communication with partners may be beneficial to determine whether these factors are also influenced by parent-adolescent communication as adolescent sexual behaviour is a wide-ranging topic (Miller, Forehand, & Kotchik, 2000). Results from this study may not necessarily be generalizable to urban populations due to participants residing in a small town in rural Alberta.

Suggestions for Future Research

Interviews with caregivers and adolescents may complement the quantitative findings by providing more information regarding parent-adolescent communication. For example, more details regarding the timing, the quality, the tone, the content, and who initiates the parent-adolescent communication, may be worthwhile examining. This way, researchers can gain more in-depth knowledge regarding the results found in this study and develop a further understanding of the personality characteristics of those females who delay the age at first intercourse (Zweig, Phillips, & Lindberg, 2002). As well, interviews or surveys with caregivers, teachers, and school counsellors will allow researchers to gain other perspectives on adolescent teens who engage in sex at later ages versus those who have sex younger. In future studies it may be important to consider conducting qualitative research to further explain quantitative findings.

Gathering further information on the topic of adolescent sexual behaviour and communication with parents regarding sex will allow professionals and caregivers to find

ways to nurture adolescent females with the goal of encouraging healthy sexual behaviours. In general, strengthening a wide variety of protective factors for female girls, one being family, would likely help to build resiliency in adolescence. A closer look at the many protective factors is essential in order to design effective programs and counselling strategies for working with adolescent females' to promote sexually healthy behaviours.

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Chapter 4 – A Practical Guide to Counselling the Adolescent Female Client: Reconnecting to the 'Authentic Self'

Act I Scene II

Adolescent girl enters the stage. She appears troubled and full of restless energy. Her body language is open and reflects her desire to engage with others, yet her attitude seems cautious and at times, dismissive. She begins to speak about herself...

There are times when counselling an adolescent girl is analogous to a play. The drama and tension are high, the silences poignant, and emotions can be over the top or completely restrained. Sessions can feel like mysteries, thrillers, or even comedies and therapists are left wondering what will happen next. It is no wonder that many counsellors love to work with adolescents. However, mere interest and a positive perception of youth is not enough for young people to move towards healing, especially for those who are at risk for engaging in unhealthy and self-destructive behaviour.

In 2003, Alberta Alcohol and Drug Abuse Commission (AADAC) found that girls were more likely to smoke (18.2%) in contrast to boys (13.1%), which has implications for their health. Also, the use of alcohol by adolescents is implicated in unintentional injuries that can lead to disability or death (Simantov, Schoen, & Klein, 2000). In a report on sexual activity among Canadian women, the withdrawal method for preventing pregnancy was reportedly used at a significant rate by adolescent females aged 15-17 years old (Fisher & Boroditsky, 2000). The withdrawal method was the third most commonly used contraceptive method in the last six months for women during sexual intercourse. Withdrawal method and other unsafe sexual practices can often lead to unplanned pregnancies and sexually transmitted infections (STI's). It was reported that 17% of women aged 18-24 had been diagnosed with an STI. Younger ages at first sexual experience can mean riskier sexual practices for some adolescents. Pregnancies tend to occur more often during primary sexual experiences (O'Donnell, O'Donnell, & Stueve, 2001). Many young women reported that their first sexual experience occurred at age 13 or 14. In a study by Robinson (2004), the average age of first intercourse for females was 15. Therefore, finding ways to foster positive decision-making in young women with regards to substances and sexuality could improve their short and long-term health as well as prevent disability and disease.

Previous studies demonstrating that a relationship exists between school, family communication, and adolescent females' sexual behaviours and has led to continued research in these areas. Findings in these areas may inspire educators, counsellors, and parents to learn effective ways to strengthen these potentially protective domains for youth with regards to sex during adolescence (Robinson, 2005). However, it may be even more beneficial for researchers to explore a multitude of ways to promote healthy behaviours in adolescent females and to examine how to strengthen the individual domain as well. Given the findings from research by Robinson (2005) and from previous

experience working with adolescents, the authors intended to answer the following research questions:

> **(i) Why do adolescent females go for counselling?**
> **(ii) What is the best approach and why?**
> **(iii) On what specific outcomes should counselling be based?**

Oftentimes, it is easier for adolescents and their caregivers to recognize behavioural or externalized symptoms, rather than the internalized emotional distress. It is most likely that a variety of concerns will become indicators for professional intervention (Sears, 2004). Whether it is the issue of destructive behaviours or it is the adolescent herself who enters into counselling, the research indicates that therapeutic interventions are often beneficial (Kazdin, 2000; Weisz, Weiss, Han, Granger & Morton, 1995). An intervention that focuses on strengths in counselling may be an effective strategy when working with adolescent females and their smoking and sexual behaviours. This paper builds upon our findings that girls who report a positive relationship with school and family have been found to engage in positive health-related behaviours. Focusing upon these areas and other protective domains at the environmental and individual levels is suggested throughout this paper as an overall approach to working with adolescent females.

Why Adolescent Females Disconnect from Themselves

Loss or fragmentation of the self is a theme often discussed by authors when examining adolescent females' transition to womanhood (Iglesias & Cormier, 2002; Pipher, 1994; Brown & Gilligan, 1992). Many times positive aspects of the self become buried during adolescence when self-doubt and self-consciousness reign. Societal pressure to conform to certain set standards, along with pubertal biophysical developmental changes, can lead to transformations in the ways teen girls express their emotions, identify with their physical appearance, experience family and peer relationships, and act at school. Pipher (1994) discusses how oftentimes during adolescence, girls "try on new roles every week – this week the good student, next week the delinquent and the next, the artist" (p.20). In addition, values and spirituality are often being explored by youth (Marcia, 1996). At the same time that adolescence can be a period of exploration of the self, for many young females, this period of growth often leads to a feeling of disconnection from the "authentic" self as the inner strengths can be shaken by the pressures of the outside world.

> "Authenticity is an *owning* of all experience, including emotions and thoughts that are not socially acceptable. Because self-esteem is based on the acceptance of all thoughts and feelings as one's own, girls lose confidence as they *disown* themselves. They suffer enormous losses when they stop expressing certain thoughts and feelings" (Pipher, 1994, p. 38).

Cultural influences, such as the media, are often looked to for answers regarding the reasons that females' tend to develop critical attitudes towards their appearance and reject themselves. For example, Pipher (1994) discusses how eating disorders often become a problem for adolescent females as it is common for teenage girls to become more disappointed with their body shape in adolescence. This can be attributed to the North American cultural emphasis on physical perfection and females as sexual objects. "Anorexic young women tend to be popular with the opposite sex. They epitomize our cultural definitions of feminine: thin, passive, weak and eager to please" (p. 175).

During the search to regain personal power and find ways to deal with the intensity of emotions that often accompany puberty, many females turn to physically destructive ways of coping with stress. The ratio of female adolescents with symptoms of depression is more than double that of young men (Nolen-Hoeksema & Girgus, 1994). According to AADAC research, "people who start smoking younger, there is a likely chance that learned coping mechanisms will carry on throughout adulthood to develop a strong dependency on nicotine" (2004). The transition to adulthood can leave females operating at sub-optimal levels in regards to mental and physical health.

Female Adolescent Health and Counselling

The attempt to conform to society's ideals, along with adolescent tendencies to explore new identities and new ways of relating in the world are often viewed as an inevitable part of adolescence. Arnett (2000) reminds us that adolescence is "culturally constructed" due to the fast paced demographic changes of industrialized societies (p. 470). Therefore, it seems reasonable to expect that many adolescent females will experience difficult times, but does adolescence have to be destructive to your health? Thus, if there is potential for stress, how can we teach adolescents to cope with it in healthy ways? In order for young females to act healthy, whether it is taking care of their physical bodies or protecting their futures through academic success, they will likely need to reconnect to and to re-align with those positive aspects of who they were, who they are, and who they want to be.

Once females are reconnected to their inner strengths that are so often "shelved" or pushed aside in an attempt to fit the highly valued and restrictive social image of "feminine", they can explore ways to protect themselves from the often overwhelming external pressures. Counselling can bring awareness regarding the social strains that surround female clients and how they are impacted by their environment. Once they feel reconnected to their authentic selves and learn to embrace all aspects of themselves, it is then that they may feel inspired to consistently incorporate healthy ways for coping with stress. From a strengths-based philosophy, before female adolescents reach for health on the outside and invest in themselves, the inner work is necessary.

Research studies have found that a strengths-based philosophy is often more beneficial for these young women to learn to pave a path towards self-healing (Saleeby, 1992;

Erkut, Fields, Sing, & Marx, 1996; Spence, Sheffield, & Donovan, 2002). Rather than attempting to change the negative and unhealthy behaviours of at-risk adolescent females, feminist psychotherapy, narrative therapy, and solution-focused therapy focus primarily on the inner strengths of their clients. When discussing the empirical benefits of this philosophy, Sharry (2004) states, "it is this *self-healing* process that a strengths-based approach to therapy aims to enhance" (p. 10). Thus, what are some things that counsellors, educators, and parents can do to effectively empower and support adolescent girls to go forward in health? In an attempt to answer this question, the following paragraphs are intended to assist professionals to re-attach female adolescents to their "authentic" selves so that they can become empowered to make healthy choices in a variety of present and future life situations.

What Prompts Adolescents to go to Counselling?

Youth that access counselling may be attending on their own initiative, or because of demands by their caregivers. At times youth are not inclined to reach out to others, which could reflect some inadequate social skills or special privacy needs. Also, accessing help from others can clash with their needs for autonomy and individuality (Oetzel & Scherer, 2003). Yet, for girls, there seems to be an inclination to convey their concerns more often than boys, "which may reflect social pressures to behave in sex-appropriate ways that intensify during adolescence for many youths" (Sears, 2004, p. 402). In addition, it has been proposed that these girls access substances or unhealthy behaviours as a way to manage distress, which in turn can become problematic (Sears, 2004). Therefore, the behaviours to cope with the internal stress become troublesome, which can lead to academic, relationship or family issues for the adolescent girl. At this point, counselling often becomes the option that is used to remedy these circumstances.

Building the Counselling Relationship

Research suggests that the success of therapy is based on certain common factors, including client factors, therapy techniques and the rapport that develops between the client and the professional (Hubble, Duncan, & Miller, 1999). It is imperative that this joining of individuals become a "collaborative working relationship" and has become known as the "therapeutic alliance" (Ogrodniczuk, Piper, Joyce, & McCallum, 2000, p. 452). This joining will also assist with those clients who are resistant to counselling, which can occur more often for mandated adolescents. Clients that perceive an alliance tend to have more favourable results when assessed post-counselling, which is why this alliance becomes a factor when working with adolescent girls (Joyce, Ogrodniczuk, Piper, & McCallum, 2003). These Canadian researchers suggest that:

> "explanations of the positive effect of the alliance on outcome often refer to beneficial common factors such as being involved in a helping relationship, hearing a convincing rationale, and receiving positive feedback about progress,

> which are believed to increase morale, a sense of mastery and positive expectations" (Ogrodniczuk, et al., 2000, p. 456).

The achievement of the alliance seems to take place in phases, but the primary objective is to create the alliance at the beginning of counselling. As well, informing the adolescent and her caregivers at the beginning of therapy about the limits of disclosure will adequately prepare everyone about what is to be expected within the counselling process. This will also provide clarity regarding the extent of adolescent and caregiver participation throughout therapy. Therefore, in order for a positive relationship to develop between the counsellor and the adolescent, it is vital that:

> "satisfactory levels of collaboration and trust must be established; the client needs to join the therapist as a participant in the therapeutic journey, agree on what needs to be accomplished and develop faith in the procedures that provide the framework for therapy" (Horvath & Luborsky, 1993, p. 567).

What appears to be crucial for the alliance is that the client believes they have support and understanding to deal with their concerns. However, experienced clinicians know that empathy is the foundation, but not enough - youth also require a stance of non-judgment, so that they can feel safe to express themselves, regardless of the actions that brought them into counselling (Oetzel & Scherer, 2003). This objective stance can be difficult when the young woman is involved in at-risk behaviours, yet the need to discuss their internal motivations and intentions can be critical when addressing problem situations. Balancing cautions for limits on behaviours with support and education requires a creative clinician that is able to repair the therapeutic relationship if necessary (Horvath & Luborsky, 1993).

Research suggests that when a client anticipates they can be helped because they are going for counselling, this "expectancy" will influence the results of their therapy (Joyce, Ogrodniczuk, Piper, & McCallum, 2003). With adolescent girls, this information is important because some of them will be the initiator of the decision to seek counselling. At the same time, other girls will be ambivalent or afraid to reach out for assistance, and this outlook may require a collaborative discussion about her views on counselling. Since this indirect expectancy effect can be mediated by the alliance, using the counselling relationship to develop her understanding of potential helpful outcomes can be beneficial (Joyce, Ogrodniczuk, Piper, & McCallum, 2003). Essentially, the more invested she is to receive relief from counselling, the more absorbed she will be in both the assignments for counselling and the alliance itself.

More important in counselling than being a 'hip' or 'cool' counsellor is genuineness and authenticity; youth may find this authenticity somewhat intriguing (Oetzel & Scherer, 2003, p. 218). When the therapist takes ownership for their responses to the adolescent, the client is able to view herself through the lens of another, which is a tricky task when

enmeshed in the egocentrism of youth. Using the skills of assertion in the early stages, instead of confrontation or ultimatums, conveys a message so that "adolescents know their therapist is committed to treating the problem" (Oetzel & Scherer, 2003, p218).

Bratter, Bratter, and Bratter (1995) state that clinicians should aim to build a relationship with adolescent clients where the client can,

> "rely on their therapist to help them chart their course and to know when and where waters might get rough, and they must trust that the clinician will take the helm if necessary, without taking over the ship. In the end, adolescents must see success as their own. The goal is not only to help them heal or recover but to build a foundation of self-confidence and resiliency in which empowerment replaces helplessness and isolation is replaced by connection".

Get to Know Herself via Solution/Strengths-based Therapy

From a social constructionist point of view, "the aim of therapy is to move from narrow stories of problems and oppression to empowering stories of strength and hope and liberation, that fit equally well with the evidence of the clients' lives" (Sharry, 2004, p. 5). Some examples of strengths-based orientations include Solution-Focused Therapy, Feminist Psychotherapy, and Narrative Therapy. Cognitive-Therapy techniques also aim to change clients' internal dialogue. Solution-focused therapy supports the idea of small steps towards a positive client goal that can be accomplished by reframing the "problem" so that the client can create new meanings (O'Connell, 1998). The goals of Narrative Therapy, developed by Michael White and David Epston (1990), and Feminist Psychotherapy are rooted in a strengths-based approach that can be therapeutic for young female clientele. These theories both support the notion of deconstructing and reconstructing ideas about the self through gentle examination of the social context (Worell & Remer, 2003; O'Connell, 1998; Payne, 2000). Through empathy and a curious stance, the counsellor can gather information around how the client has become who she is. By externalizing the "problem" identity that the client has personalized and holds for herself, the counsellor can assist the client in breaking this identity down to rebuild a "strengths-based" identity (White & Epston, 1990). The following table summarizes the strengths-based philosophy of counselling that can also be applied to working with adolescent females.

Table 4-1. Summary of solution/strength approaches to counselling.

Solution Focused
1. Focuses on understanding how change occurs in clients' lives and what positive possibilities are open to them. 2. Elicits detailed description of goals and preferred futures. 3. Person is seen as more than the problem, with unique talents and strengths and a personal story to be told 4. Focuses on identifying 'what's right and what's working', on strengths, skills and resources in individuals, families and communities. 5. Highlights and appreciates any time the client co-operates or goes along with the therapist's questions. 6. Therapy can be brief in creating 'pivotal' change in clients' lives. 7. Trauma is not necessarily predictive of pathology as it may weaken or strengthen the person. The therapist is interested in discovering how the client has coped with the trauma. 8. Treatment plan is a collaborative endeavour between therapist and client, with their respective expertise. (Client as expert in their own lives and therapist as expert in therapeutic process.)

adapted from Sharry (2001b, 2004)

Focus on Risk and Protective Factors

AADAC has identified five areas that contain factors that interact to influence the behaviours of adolescents. These are the individual, peers, family, school and community. For example, within the school environment, youth will be more likely to be "protected" from negative behaviours when they experience school connection and high grades. They become more "at risk" for negative outcomes when they are likely to be leaving school early and are having school problems (AADAC, 2003). These domains have consistently been identified as creating an arena of support for adolescent development.

Rather than examining the current "problems" the female may be experiencing, that is, dealing with only parts of who she is, it will likely be more therapeutic if counsellors find out about the "whole" client. Exploring the female client's world of peer and family relationships, school likes/dislikes, hobbies and interests, etc. can allow the therapist to gather important information about who the client is and can assist the counsellor and the client in the direction of her treatment needs. Once these risks and assets are identified for her client, a clinician can use this knowledge to interact with adolescent girls and to build a case conceptualization.

Since this "strengths" perspective is so valuable for understanding youth, it is advised that counsellors be aware of the research from this field (see De Jong & Miller, 1995). Initially, by educating adolescent females about their unique risks and assets and gaining

insight of the meaning of the client's perspective, clients can become empowered to shift their perspectives so that healthier life decisions can be made. This information can be used to emphasize her adaptive functioning, which "facilitates adolescent girls viewing their world within context, rather than as personal failures" (Johnson, 2001, p. 108).

This active construction of themselves and their environment can build social awareness, at a time when many girls are becoming interested in issues such as the environment, animal rights, and the influence of media, which are outside themselves/ beyond their inner world. This exploration of the different aspects of the client's life can aid counsellors and clients in seeing the "big picture". These interventions can build "resiliency characteristics" for her to use as buffers in challenging situations and environments (Bell, 2001). In addition, this process will likely make the client feel cared about and that her opinion matters. When it is communicated that the adolescent client's views and positive personal qualities are accepted and valued by the adult counsellor, the client may also begin to recognize, accept, and value these strengths herself.

Specialists also advise that clinicians become aware of the socioeconomic and cultural dimensions that influence adolescent girls within their communities (Johnson, 2001). Having cultural competence assists with the development of the therapeutic relationship and encourages girls to educate their counsellor, which leads to greater sharing and support. The exploration of these issues may lead to untapped protective factors such as spirituality or cultural resiliency (Querimit & Connor, 2003). For example, Aboriginal girls often experience marginalization and isolation within urban communities. Asking about her personal stories can create a narrative that articulates the "risk" domains she experiences; the strengths discovered can affect her outlook on herself, her family and her culture. As well, helping her resolve societal injustices through education and support leads to a greater understanding of her capacity to cope and decreases her personal responsibility for experiencing these injustices. As Iglesias and Cormier (2002) have suggested when discussing ways to find the voice of adolescent females:

> "A girl who will develop as a woman who embraces freedom has a strong sense of self-confidence and self-efficacy. She knows how to make friends, she respects and cares for her body, she knows what she thinks and feels, and she embraces the freedom to express her true self. She feels empowered in school and social situations. She recognizes and is able to challenge and resist situations of discrimination, oppression, and harassment, and she feels aligned with the positive aspects of her unique cultural heritage" (p. 266).

Finding Health in Obscure Places

Exploring how aspects of the self have evolved for the client may reveal whether some positive qualities are in "hiding", and are often unrecognized by society's standards. Once these hidden qualities have once again been identified, the client and therapist can create goals for the future and the client can decide whether or not she would like to build

upon these aspects of herself; that she might be unaware of or have unwittingly buried in response to the influential societal pressures.

In a qualitative study with "high-risk" Canadian youth regarding mental health and empowerment, Ungar and Teram (2000) found themes around the importance of social acceptance for these youth, and the need to feel personal power. They found that even though the behaviours of these youth are often labelled "unhealthy" from the outside, that their behaviours may actually be maintaining their mental health. Unfortunately, these coping mechanisms may be destructive to their physical health. Essentially, it is that these youth lack the resources to engage in physically healthy behaviours that maintain their mental health; that they are actually using what is accessible to them as a way to remain mentally healthy, even though their physical health may be impacted negatively. For example, the girl who identifies herself as the head of a female gang is using her leadership strengths to gain personal power, even though she is exposed to potentially harmful risks. These researchers suggest that counsellors should search for the health in even those behaviours that appear unhealthy to gain insight on the meaning the client holds for her current identity. Empathic counselling seems an imperative part of this journey towards self-acceptance. Once the client and the counsellor reach a deeper understanding regarding these typically "unhealthy" behaviours, perhaps new behaviours can be introduced to serve a similar purpose for the client.

> "Narratives of personal agency may challenge the stories of oppression that dominate the lives of troubled youth. Professionals should also facilitate opportunities for these youth to express their strengths in positive ways" (p. 249).

By examining social influences and the external forces that contributed to the "problem" identity, the female client can take a breath from self-criticism and begin to explore herself from a less judgmental stance.

> "The process of deconstruction erodes the power of these dominant stories in the lives of those it touches. It makes possible to highlight alternative meanings" (Seu & Heenan, 1998, p. 32).

Therefore, once youth become aware of their strengths and their assets, they may feel inspired to explore new ways of behaving in order to maximize these strengths on both a mental and a physical level.

Introduce Healthy Ways for Coping with Stress: Using Creative Media and Exercise in Therapy

Counsellors who use creativity in therapy with adolescent females can open several avenues for healing. Art, music, poetry, clay work, and journaling are just some of the ways in which adolescents can be engaged in therapy. Learning a variety of ways to effectively release and cope with emotions will equip young people with further tools for

moving towards health. As well, for some, these forms of expression can be less direct and less threatening than verbal communication. For example, letter writing can be a way for adolescents to communicate feelings regarding their life situations without speaking directly to their counsellor. Epston (1994) suggests exercises such as letter writing to the self to externalize the concerns and create links for clients to reach a new perspective on themselves. Other types of externalizing therapy include art therapy, which is described as:

> "a means to discover both the self and the world, and to establish a relation between the two. In the complete creative process, inner and outer realities are fused into a new identity" (Ulman, 2001, p. 22).

Teenage girls who are engaging in risky behaviours can be viewed as harming their physical bodies due to a lack of connection or lack of respect and education regarding their bodies. Connecting females to their physical bodies may be therapeutic, as there is so much rejection of the female body during these years. As the female body fills out and hips widen, for example, sometimes body image can become distorted due to the cultural messages around the value of female thinness.

Therapists can recommend exercise as part of therapy, but not necessarily with the intention that their clients lose weight. "Positive" reasons to exercise (such as for mood, health, enjoyment and fitness) have been linked with higher self-esteem, when compared to "negative" reasons (weight control, attractiveness, and tone) which have been associated with eating disorders and low self-esteem in adolescents (Furnham, Badmin, & Sneade, 2002). A greater gap between ideal and actual body shape existed for girls (N=124) more than boys (N=111) as did disappointment with weight, and eating attitudes and behaviours. These 12-13 year old girls were also found to exercise for weight loss more than boys of the same age, who exercised for body fitness. Challenging females' views by exploring the social messages around exercise and the female body may be helpful. Perhaps, introducing the idea that all of our parts are important and that they need to be cared for may lead to new ways of thinking about the body. An example of an exercise that aims towards integrating the mind and the body is yoga.

> "By enabling us to go inward – to focus on how we *feel* in a pose rather than how we *look* – yoga encourages us to let go of our desires for our body and criticisms of it, to enjoy its movements. Over time, this experiential relationship with our body may even enable us to forsake the mirror for our internal seer, to filter out social pressures and unrealistic expectations, and to accept ourselves as we are" (Isaacs, 2004, p. 108).

As with other therapeutic goals, this process of introducing physical activity in therapy will likely be most successful when both the client and the counsellor collaboratively design the exercise goals. In addition, it is important that clients are referred to their physicians prior to starting a physical fitness regime. It may be worthwhile to review the

literature when exploring useful strategies for introducing exercise as a therapeutic intervention (see Okonski, 2003; Chung & Baird, 1999).

Connect Females to the Community.

Linking adolescents to adults in the community increases the support network of the youth. It may be beneficial to refer teens to resources such as career centres, volunteer and/or job opportunities, activities in the community and at school. These can also include referrals to school counsellors and health practitioners as they can further educate teens regarding family planning, STI's, etc, depending on the needs of the client. Adult mentoring may also be a path to consider if resources are available. Group counselling, Family Therapy, and Social Skills Training can become other supports as these are ways that teens can become more connected to their peers, family and can be opportunities for gaining important life skills.

By exploring the interests of the client, a collaborative plan can be devised with the aim of connecting to the community. Educating teens about what is available in their communities and connecting them with a variety of positive adult models is important. The more resources and supportive people that are introduced to the adolescent, based on their strengths and needs, the more the pathways of health become visible. When adolescents become aware of the multitude of areas they can draw from in the community, they may be better able to choose healthy ways to feel powerful and valuable.

When Counselling Ends

Awareness that counselling will be completed can be a therapeutic issue for both the client and therapist and it is important that this be addressed in order for successful completion of therapy. It is recommended that this event be reviewed on an on-going basis as a way to check in with progress and the successful completion of goals. The best case scenario is that, "therapy ends when the person decides that her self-story is rich enough to sustain her future" (Payne, 2000, p. 17). It is up to us as counsellors to provide an environment where there are healthy boundaries and that endings are not only understood as a negative occurrence, but also as an opportunity for growth and transition. Payne (2000) states that the last meeting can be treated like a celebration, where confirmation for success can be recognized. Booster sessions can be scheduled at the penultimate session for the client to check in regarding resolution of the issues that brought her into counselling. Scheduling booster sessions can also increase motivation for attendance of the final session for those clients that are likely to avoid the discomfort of endings.

Act II Scene I – Final Act

Adolescent stands tall, holding her head up high. Her eyes are bright and she is smiling. There is a light that seems to resonate from the inside out. She feels proud of who she is and is excited about her future. She catches a glimpse of herself in a mirror and appreciates what she sees, for she sees that every part of herself encompasses true beauty. She begins to treasure and invest in herself and acts in ways that reflect her inner peace. She no longer needs to search outside herself for validation, for she knows how to tap into her strengths and provide herself with the nourishment she needs. Adolescent girl exits the stage.

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Chapter 5 – Summary

Findings are summarized and limitations are identified in this final chapter. Ideas for future research will also be discussed.

Research Findings

Paper I: School Factors and Contraceptive Use at First Intercourse

The purpose of this study was to see which of five school factors (GPA, educational aspirations, attachment to school, weekly time spent studying, and weekly homework time) best predicted contraceptive use at first intercourse. Data from sexually active female students (n=123) on the *Student Health Survey* (SHS) was used (Hess & Schnirer, 1996) (see Appendix A). The five school factors were analyzed through logistic regression and indicated that *weekly studying time* predicts the use of contraceptives at first intercourse for adolescent females. In addition, a trend was reported between GPA and contraceptive use at first intercourse. Those females who reported higher GPA's also tended to report more contraceptive use at first intercourse.

The *Study Time* variable was statistically significant at the $p<.05$ level (95% confidence level) with a Wald statistic of 7.989 ($Exp[\beta]=2.565$, $df=1$). The Model chi-square statistic was significant at the .05 level. The four other school-related factors were not found to significantly predict contraceptive use at first intercourse for females in this study.

This paper makes an important contribution to the research by revealing that the school domain, and *studying* in particular, can play a protective role when it comes to adolescent females' sexual behaviour. For example, if academic skills such as study skills are introduced and strengthened for those females at risk for early pregnancy or STI's, a higher value may be placed on "academic identity" and if resources such as school are strengthened females may be more apt to refrain from engaging in risky sex. Using contraception at first intercourse decreases the chances for unwanted pregnancies and STI's and increases the chances that contraceptives will be used in the future. When researchers examine the positive behaviours of those females who are acting in sexually healthy ways, this increases our knowledge of how to design effective programs and what to focus upon when working with teen girls.

Paper II: Perceived Communication with Parents regarding Sex and Sexual Debut

The aim of this study was to examine parent-adolescent communication and age and contraceptive use at first intercourse for adolescent females. It was hypothesized that those females who perceive communication with parents about sex would also report later age and increased use of contraceptives at first intercourse.

A one-way ANOVA was performed and it revealed that perceived communication with

parents is related to age at first intercourse for adolescent females ($F(1, 120)=6.67$, $p<.05$). Data from sexually active female students (n=123) from the SHS who perceived communication with their parents regarding sex were found to report delayed age at first intercourse ($M=15$, $SD=1.41$), compared with those females who perceived no communication with parents ($M=14$, $SD=1.19$).

A chi-square analysis was performed but found no significant relationship between parent-adolescent communication and contraceptive use x^2 (1, N=123) = 1.89, $p>.05$). Therefore, results from this study failed to confirm the second part of the hypothesis that those females who perceived parent-adolescent communication would report more use of contraceptives at first sex. This may be an indication that the content of parent-adolescent discussions are worth studying in order to determine whether parents and teens are including the topic of contraception in their talks about sex and whether including this topic in discussions would impact teen contraceptive use.

This paper also makes an important contribution to the research as findings indicate that, like the school domain, the family domain likely plays a protective role in regards to adolescent females' sexual behaviour. Later age at sexual debut for adolescent females may prevent negative consequences of risky sexual behaviours such as STI's, unwanted pregnancies, and negative emotions that are often linked with early sexual experiences for females. It may be beneficial for educators, counsellors and parents to find effective ways to develop sexual communication skills between adolescent females and their parents and to strengthen the parent-teen alliance.

Paper III: A Practical Guide to Counselling the Adolescent Female Client: Reconnecting to the 'Authentic Self'

This paper was written by taking a step back after reviewing the results found in the above studies and other findings examining the health behaviours of adolescent females. This paper was intended to assist professionals and caregivers who work with adolescent females to emphasize positive strengths to promote healthy behaviours, rather than focus on the risky behaviours. A strength-based approach was suggested with a focus upon assets and risks with regards to assessing the needs of individual females. Strengthening connections and supports in domains such as family, school, and at the individual level may provide the necessary prevention needed with regards to adolescent health behaviours.

Integrating a variety of ideas for working with adolescent females will enable counsellors to focus upon many aspects of the individual female client. A strength-based approach may be an effective way to positively connect females to those qualities that make them unique and that they would like to build upon. A positive approach with teen females that explores their individuality in a variety of ways, such as connecting to their physical bodies, and connecting to their communities, may teach teens how to protect themselves from adverse pressures during adolescence.

Limitations of this Study and Future Suggestions

Data from the survey (SHS) was collected in 1994 and the questions used for this study were previously designed. Therefore, further information could not be collected from this population of rural Albertan adolescent females. Collecting qualitative data would likely offer explanations regarding the findings that weekly study time predicts contraceptive use at first intercourse for this sample of females. For instance, interviewing parents, teachers, and students could provide more insight regarding the qualities of those females who do study and act in sexually healthy ways. In addition, it is difficult to draw conclusions from these results due to the fact that specific school factors have not been examined in the literature, to a great extent; especially variables such as weekly time spent studying and doing homework.

The chapter that examined perceived parent-adolescent communication regarding sex could have also benefited from open-ended interviews with the female participants and their caregivers. Gathering personal reports regarding the content, timing, tone, and quality of communication could present ideas to assist professionals and caregivers in learning how to strengthen the family domain. According to Bronfenbrenner's (1979) ecological theory, developing effective ways to strengthen supports such as school and family connectedness may prevent risk taking and promote healthy behaviours in adolescence.

Future studies may consider taking a closer look at the four domains of support (family, school, peers, and individual) suggested as assets or risks in the ecology theory of human development (Bronfenbrenner, 1979). Studying these domains in greater detail may lead to more direct and effective ways to inspire and support youth to act in healthy ways. It may also be beneficial to examine the sexual behaviours of females in greater detail. For instance, collecting qualitative and quantitative information regarding a range of sexual behaviours such as contraceptive use, age at first intercourse, and number of partners and comparing these behaviours with the four domains may yield interesting findings. In addition, examining more closely the domains and the personality characteristics of those females who are behaving in healthy ways may be a positive approach to identifying the qualities that we as professionals and caregivers can attempt to nurture (Zweig, Phillips, & Lindberg, 2002). The more detail we can gather on the topic of adolescents and sexual behaviour, the more that strategies can be developed to assist youth in strengthening their connections with these important areas of their lives; including the relationships that they have with themselves.

In Conclusion

Now looking back on my own transition from girlhood to adolescent it is easy for me to identify that I, like so many young women, experienced my own process of loss and fragmentation. I consider going from happy-go-lucky and confident at twelve to cautious and uncertain at thirteen, a loss. I can now see that this process occurred, but unfortunately, I cannot pinpoint exactly how or why. I can attribute some of it to cultural

pressures and to difficult life experiences, but perhaps it is what is absent or lacking that impacts us the most. I do see now how my own feelings of connectedness to family, school, and peers likely protected me from many pressures during adolescence, however, my connection to and my relationship with myself somehow got lost in the shuffle. I am aware now that when I feel connected with myself, I also treat myself in loving and healthy ways. I think that Bronfenbrenner (1979) had a point, that when domains are healthy, so are children and teens.

Over the past fifteen years I have seen glimpses of my child-self, that 'unconscious' confidence, the unbeatable optimism. However, it is just now in my late twenties, that I feel I am finally acknowledging my own process of fragmentation and am fully reconnecting again to my 'authentic' self. Why has it taken so long? And, did this have to occur in the first place? I guess I may never know.

What I do know is that exploring this process and reflecting back on my own adolescent experience has led me to the research of adolescent females. This research has, in turn, encouraged me to continue reviewing my own life process and to continue to study this intriguing population. I hope that as a parent, and as a counsellor, this research and this reflection upon my own process will enable me to help nurture teens and develop strong working relationships with adolescent clients, as well as close relationships with my children and with myself.

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Appendix A

Instrument

Student Health Survey

Questionnaire

Introduction and Directions

This questionnaire is completely **anonymous** and **voluntary**. We are interested in your dating experiences as well as your impressions of the dating habits of other teens. **We really want honest answers to the questions, but please feel free to skip any questions that you do not want to answer.** Your participation in this survey will help us better understand the dating trends of today's teenagers, and will help us make the CALM course more relevant to teenagers' needs. Thank you for your participation.

Part 1 – Background Information

1. What is your sex (gender)?

   (1) male (2) female

2. What is your age?

   (1) 14
   (2) 15
   (3) 16
   (4) 17
   (5) 18
   (6) 19 or older

3. What grade are you in ?

   (1) 10 (2) 11 (3) 12

4. What is your cultural background?

   (1) European Please Specify:_____
   (2) Native
   (3) Other

5. Please indicate the statement about religion which best describes you.

   (1) I never go to church
   (2) I rarely go to church
   (3) I sometimes go to church, but not regularly
   (4) I regularly go to church, usually once a week
   (5) I regularly go to church, and am involved in religious activities during the week as well

6. Do you consider yourself religious?
   (1) Not at all
   (2) Less religious than most teens my age
   (3) More religious than most teens my age
   (4) Yes, very
   (5) Other_____(write in)

7. Please mark the statement which, in your opinion, best describes your physical appearance.
   (1) I do not consider myself attractive to others
   (2) I am not really attractive, but I do have some nice features
   (3) I think that I am average in attractiveness
   (4) I think I am more attractive than others
   (5) I consider myself one of the most attractive people in my school
   (6) Other_____(write in)

8. Where do you live?
   (1) in a city (3) on a reserve (5) Other_____
   (2) on an acreage (4) on a farm

9. Do you have access to a vehicle to drive, either your own, or your parents?
   (1) I am not old enough to drive
   (2) Yes
   (3) No
   (4) Sometimes

10. Please mark the statement which best describes your parents/guardians:
   (1) I live with both of my biological parents
   (2) I live with my mother who is a single parent
   (3) I live with my father who is a single parent
   (4) I live with my mother and stepfather
   (5) I live with my father and a stepmother
   (6) Other_____(write in)

11. Please mark the statement which best describes the parents or guardians you are currently living with:
   (1) My parents/guardians are very strict
   (2) My parents/guardians are strict
   (3) My parents/guardians are not very strict

12. Please mark the statement which best describes the parents or guardians you are currently living with:
   (1) I have a good relationship with both my parents/guardians, (or with one parent if living with a single parent)
   (2) I get along with my mother/stepmother, but not with my father/stepfather
   (3) I get along with my father/stepfather, but not with my mother/stepmother
   (4) I do not have a good relationship with either of my parents/guardians, (or one parent if living with a single parent)

13. Have you ever talked to your parents about sex?
    (1) yes, a great deal
    (2) yes, a bit
    (3) no, not at all

14. Do you like school?
    (1) I love school
    (2) I like school more than most of my friends
    (3) It's OK (average)
    (4) I don't like school very much
    (5) I hate school
    (6) Other_____(write in)

15. Do you participate in extra-curricular activities?
    (1) Yes, as much as I can
    (2) Yes, a little
    (3) I don't participate in extra-curricular activities

16. Do you have chores to do after school?
    (1) Yes, I have regular chores to do after school
    (2) Yes, I sometimes have chores to do but not everyday
    (3) No, I don't have chores to do after school

17. Do you have a job after school?
    (1) Yes, I have a regular paid job
    (2) I sometimes do odd jobs for money but nothing regular
    (3) I do not have any job for money

18. How many hours per week, on average, do you work during the school year?
    (1) I do not have a job
    (2) 1 to 5 hours
    (3) 6 to 10 hours
    (4) 11 to 15 hours
    (5) more than 15 hours

19. How much time, on average, do you spend doing homework each week?
    (1) None
    (2) Less than one hour
    (3) 1-2 hours
    (4) 3-5 hours
    (5) More than 5 hours

20. How much time, on average, do you spend studying each week?
    (1) None
    (2) Less than one hour
    (3) 1-2 hours
    (4) 3-5 hours
    (5) More than 5 hours

21. What are your plans immediately after completing high school?
    (1) continue my education at a university
    (2) continue my education at a college with the intention of transferring to a university after one or two years
    (3) continue my education at a college (e.g., NAIT, Grant MacEwan)
    (4) to get a job
    (5) to travel
    (6) I don't know yet
    (7) Other_____(write in)

22. What career, or job, do you intend to pursue when you finish your education?
    (1) _____(write in)
    (2) I don't know yet

23. What is your approximate grade average in school?
    (1) less than 40% (3) 50-65% (5) 80 to 100%
    (2) 40-50% (4) 65-80%

24. Which statement best describes your use of tobacco?
    (1) I never have used any tobacco products
    (2) I have rarely smoked or chewed tobacco
    (3) I am an occasional smoker (or chewer) of tobacco
    (4) I used to use tobacco products, but have quit
    (5) I smoke (or chew) tobacco regularly

25. Which statement best describes your use of alcohol?
    (1) I never drink alcoholic beverages
    (2) I used to drink alcohol, but I have quit
    (3) I occasionally drink alcoholic beverages
    (4) I drink alcohol regularly, but don't usually get drunk
    (5) I drink alcohol regularly, and often get drunk

26. How many alcoholic drinks would you have in an average week?
    (1) I don't drink alcoholic beverages
    (2) 1-3 drinks / week
    (3) 4-6 drinks / week
    (4) 7-10 drinks / week
    (5) more than 10 drinks / week

27. When do you drink alcoholic beverages? (You may choose more than one).
    (1) I don't drink alcoholic beverages
    (2) Only at family functions
    (3) Only at parties on the weekends
    (4) Only on weekends
    (5) Sometimes during the week, as well as weekends
    (6) I drink alcoholic beverages during the week and on weekends

28. Have you ever used illegal drugs?
    (1) Never
    (2) Only a few times (less than 5)
    (3) Occasionally (less than 10)
    (4) Frequently

29. Have you ever used prescription drugs or "over-the-counter" drugs, for recreational (non-medical) reasons?
    (1) never
    (2) only a few times
    (3) occasionally
    (4) frequently

Thank you. Please go on to Part 2.

Part 2 – Peer Expected Dating Behaviours

This part of the questionnaire asks you to think about the **majority** of the teens in your school, and to **predict what you think** most of them would do while on a date.

To help you with this portion of the survey, a brief definition of the terms used has been given below:

Date: when a boy and a girl plan to meet alone or in a group at some place at some time
Going steady: going out with only one person, in a mutually exclusive relationship
Kissing: casual kissing, once or twice on a date
Necking: more prolonged kissing, with cuddling and stroking of the hair and face
Light petting: fondling of the body with the hands
Heavy petting: prolonged fondling, often with the removal of clothing
Sexual intercourse: full sexual relations (go all the way)

1. Two people like each other, and are on a **first date**:

If two people who liked each other, and are on a first date, would you expect them to...

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

2. Two people who have **gone out several times**:

If two people have gone out several times as a couple, would you expect them to…

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

3. A couple that is **going steady**:
If a couple were going steady, would you expect them to…

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

4. A couple that is in a **serious, committed relationship**:

If a couple were seriously thinking about marriage, or were in a deep, committed relationship, would you expect them to…

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

Thank you. Now go on to Part 3

Part 3 – Actual Dating Behaviours

These questions are intended to gather information about behaviours of young Canadians while on dates. We are interested in **your** experiences. Please give us your honest answers. **Again, you may leave out any question(s) which you feel you would rather not answer.**

To assist you with this portion of the survey, a brief definition of the terms used has been given below:

Date: when a boy and a girl plan to meet alone or in a group at some place at some time
Going steady: going out with only one person, in a mutually exclusive relationship
Kissing: casual kissing, once or twice on a date
Necking: more prolonged kissing, with cuddling and stroking of the hair and face
Light petting: fondling of the body with the hands
Heavy petting: prolonged fondling, often with the removal of clothing
Sexual intercourse: full sexual relations (go all the way)

I. While on a **first date** with someone:

1. Have you ever been on a date with a person of the opposite sex? (See definition of "date" above).
   (1) Yes (2) No

2. How many different people of the opposite sex have you ever dated?
   (1) I have never been on a date
   (2) I have only dated one person
   (3) I have dated a few people (up to 5)
   (4) I have dated more than 5 people

3. On any of the first dates with someone you liked did you ever? (Choose Yes, No, or Not sure for all 6 categories or check #7)

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

(7) I have never been on a date

II. After **going out several times** with one person:

1. Have you ever had several dates with the same individual of the opposite sex?

   (1) Yes (2) No

2. How many different people of the opposite sex have you ever had several dates with?

   (1) I have never been on a date
   (2) I have only been on more than one date with one person
   (3) I have been on more than one date with several people (up to 5)
   (4) I have been on more than one date with more than 5 people

3. After several dates with the same person did you ever....?
(Choose Yes, No, or Not sure for all 6 categories or check #7)

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

(7) I have never been on several dates

III. While **going steady:**

1. Have you ever gone steady with a person of the opposite sex?

   (1) Yes (2) No

2. How many different people of the opposite sex have you ever gone steady with?
   (1) I have never gone steady
   (2) I have only gone steady with one person
   (3) I have gone steady with several people (up to 5)
   (4) I have gone steady with more than 5 people

3. While going steady with someone of the opposite sex did you ever?
(Choose Yes, No, or Not sure for all 6 categories or check #7)

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

(7) I have never gone steady

IV. While in a **serious, committed relationship**:

1. Have you ever been in a serious, committed relationship:
   (1) Yes (2) No

2. While in a serious, committed loving relationship with someone of the opposite sex did you ever?
(Choose Yes, No, or Not sure for all 6 categories or check #7)

	Yes	No	Not sure
(1) hold hands?	1	2	3
(2) kiss?	1	2	3
(3) neck?	1	2	3
(4) light pet?	1	2	3
(5) heavy pet?	1	2	3
(6) "go all the way"?	1	2	3

(7) I have never been in a serious, committed relationship

Thank you. Please go on to Part 4.

Part 4 – Sexual Attitudes and Behaviour

The following questions deal with your sexual attitudes and behaviour. (Please remember that your answers are totally confidential and voluntary). **No one will ever know what your particular answers are to any of these questions.** Again, feel free to leave out any questions which you would rather not answer.

1. Have you ever had sexual intercourse? (Going all the way…i.e., with penetration)
   (1) Yes (2) No

2. How many times have you had sexual intercourse?
   (1) I have never had sexual intercourse
   (2) Once
   (3) 2-5 times
   (4) more than 5 times

3. With how many different partners have you had sexual intercourse?
   (1) I have never had sexual intercourse
   (2) 1 partner
   (3) 2-5 times
   (4) more than 5 times

4. How old were you when you first had sexual intercourse?
   (1) I have never had sexual intercourse
   (2) 11 or younger
   (3) 12
   (4) 13
   (5) 14
   (6) 15
   (7) 16
   (8) 17
   (9) 18
   (10) 10 or older

5. How would you describe your condition when you first had sexual intercourse?
   (1) I have never had sexual intercourse
   (2) sober
   (3) had a few drinks
   (4) drunk
   (5) stoned
   (6) I don't remember
   (7) other_____

6. Were you coerced (heavily persuaded) into having your first sexual intercourse?
   (1) I have never had sexual intercourse
   (2) Yes, I felt coerced. I did not really want to do it
   (3) No, I did not feel coerced. I was quite willing to have sex at that time

7. Where did you have your first intercourse?
   (1) I have never had sexual intercourse
   (2) at home
   (3) at my partner's home
   (4) at someone else's home
   (5) in a vehicle
   (6) other_____

8. Who initiated (wanted to have) sexual intercourse first?
   (1) I have never had sexual intercourse
   (2) I did
   (3) my partner did
   (4) we both did
   (5) I don't remember

9. Did you discuss birth control with your partner before having intercourse?
   (1) I have never had sexual intercourse
   (2) Yes
   (3) No, but we talked about birth control after having intercourse
   (4) No, we have never talked about birth control, either before or after having intercourse

10. Who initiated the discussion (first brought up the subject) about birth control?
   (1) I have never had sexual intercourse
   (2) I did
   (3) my partner did
   (4) I have had sexual intercourse but I have never discussed birth control
   (5) I don't remember

11. Did you use any form of birth control when you had your first sexual experience?
   (1) I have never had sexual intercourse
   (2) Yes
   (3) No
   (4) I don't remember
   (5) I don't know

12. If you used a method of birth control, please identify the method used:
   (1) I have never had sexual intercourse
   (2) Did not use birth control
   (3) Birth control pill
   (4) Withdrawal
   (5) Vaginal spermicides
   (6) Condom
   (7) Diaphragm
   (8) others_____ (write in)

13. If you did not use birth control, would you please explain why you chose not to
   (1) I have never had sexual intercourse
   (2) I just didn't think about it
   (3) other_____

14. The following adjectives have been used by young people to describe their first sexual experience. Please check off the one(s) that you feel best describes your emotions about your first encounter with sex. Check as many as you feel best describe your emotions at that time.

(1) I have never had sexual intercourse
(2) Guilty
(3) Afraid
(4) Raped
(5) Anxious
(6) Worried
(7) Betrayed
(8) Hurt
(9) Wonderful
(10) Stimulated
(11) Loved
(12) Mature, Grown-up
(13) Fulfilled
(14) Excited
(15) Superior
(16) Other_____

15. Who influenced you to make your decision to have sexual intercourse? (please write a 1 beside the one who influenced you the most, a 2 beside the next and so on until you have ranked all those you feel have most influenced you)

(1) I have never had sexual intercourse
___(2) sexual partner
___(3) friends
___(4) mother
___(5) father
___(6) sibling(s) (brother or sister)
___(7) school classes (e.g., CALM)
___(8) TV and/or movies
___(9) magazines or other print materials
___(10) other_____(write in)

16. Who influenced you to make your decision NOT to have sexual intercourse? (Please write a 1 beside the one who influenced you the most, a 2 beside the next and so on until you have ranked all those you feel have influenced you)

(1) I am sexually active
___(2) my partner
___(3) friends
___(4) mother
___(5) father
___(6) sibling(s) (brother or sister)
___(7) school classes (e.g., CALM)
___(8) TV and/or movies

17. From whom have you received your knowledge about sex?
(Please write a 1 beside the one who influenced you the most; a 2 beside the next and so on until you have ranked all those you feel have influenced you)

(1) I am sexually active
___(2) my partner
___(3) friends
___(4) mother
___(5) father
___(6) sibling(s) (brother or sister)
___(7) school classes (e.g., CALM)
___(8) TV and/or movies

18. Have you ever been pregnant?
(1) Yes
(2) No
(3) Irrelevant because I am female

19. Have you ever got a girl pregnant?
(1) Yes
(2) No
(3) Irrelevant because I am female

20. If you have been pregnant did you…
(1) I have never been pregnant
(2) Keep the baby
(3) Have an abortion
(4) Give the baby up for adoption
(5) This question is not relevant to me because I am male
(6) Other_____(write in)

21. If you have got a girl pregnant, did you…
(1) I have never got a girl pregnant
(2) Decide with the girl to keep the baby
(3) Decide with the girl to have an abortion
(4) Decide with the girl to give the baby up for adoption
(5) I was not part of the decision made
(6) I did not agree with the decision made
(7) This question is not relevant to me because I am female
(8) Other_____(write in)

Thank you. Please go on to Part 5 now.

Part 5 – Comments

The final say is yours. Please feel free to make any comments on these as well as any other issues you feel are important this time.

Once again, please remember that your answers are completely confidential and voluntary. No one will ever know what your particular answers are to any of these questions. You may omit questions which you would rather not answer.

1. Explain what "going steady" means in your opinion in your school.

2. How long do you think a person should go with someone before becoming sexually active?

3. Do you now, or have you in the past, felt any pressure to become sexually active?
(1) Yes (2) No

If you answered yes, from who or what do you feel pressure? You may identify more than one. (please do not use any names, just give the relationship e.g., friend, mom, TV.)

4. Do you now, or have you in the past, felt any pressure to abstain from sex, or to NOT become sexually active?
(1) Yes (2) No

If you answered yes, from who or what do you feel pressure? You may identify more than one. ({Please do not use any names, just give the relationship e.g., friend, mom, TV.)

5. Do you think it is realistic of educators and health officials, as well as, parents, to expect teenagers to practice abstinence (to not have sex)?

(1) Yes (2) No

Please explain why or why not.

6. Please feel free to make any final comments you like about teenage dating behaviours, teenage sexual behaviours and/or anything you feel may be of benefit to the researchers about this topic.

Thank you for your participation.